

PATIENT HISTORY - CHILDREN

Welcome to Cardinia Dental.

The information of which you provide, is completely confidential and protected by the provisions of the Federal Privacy Law Legislation.
Your assistance in completing our acquaintance form assists us to provide to your child, dental care of the highest standard.

Surname:..... Title: Master Mr Miss Other

First Name:..... Preferred Name:.....

Date of Birth:...../...../.....

Home Address:.....

Postal Address:.....

Parent's Names:.....

Home Phone:..... Work Phone:.....(Mother).....(Father)

Mother's Mobile:..... Father's Mobile:.....

Email:.....

Dental Insurance Details: Name of Fund:..... Number next to child's name:.....

Medical Doctor:..... Doctor's Phone Number:.....

Doctor's Address:.....

Emergency Contact: Name (Person "not" living at your address):.....

Relationship (Friend/Relative,etc):..... Phone Number:.....

Address of emergency contact person:.....

Do you have Ambulance Cover? (Please Circle) YES/NO

Name of person responsible for payment of fees:..... Relationship:.....

MEDICALHISTORY

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? PLEASE TICK:

Rheumatic Fever	<input type="checkbox"/>	Hepatitis A,B or C	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Aids/HIV	<input type="checkbox"/>	Heart Ailment	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	Neck/Back Problems	<input type="checkbox"/>
None of the Above	<input type="checkbox"/>				

List any other previous illnesses:.....

Does your child have any allergies? (Please List).....

Is He/She presently under any medical care? (Give Details).....

Please list any medication your child is taking:.....

Does your child have: any prosthetic implants or artificial heart valves? (Give Details).....

Has your child ever had any problems with previous dental visits? YES/NO/FIRST VISIT

THANK YOU FOR YOUR ASSISTANCE

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place my child at undue medical risk, I understand that I am personally responsible for all services rendered and acknowledge that payment is expected on the day of treatment. All overdue accounts will incur a monthly account keeping fee. In the event an overdue account is referred to a debt collection agency I will be responsible for all additional fees and charges.

Sign:..... Date:.....

Name:..... Relationship to child:.....