Centre Dentaire Abras

Patient's Surname **Patient's Name**

Birthday	**Age**	**Height**	**Weight**	**Sex**	**F** **M**
Street Address **Apt.** **City** **Postal Code**					
Father's Name and Surname		**Employer**		**Business Tel.** **Home Tel.** **Cell.**	
Mother's Name and Surname		**Employer**		**Business Tel.** **Home Tel.** **Cell.**	
School Name **Grade** **Child's Spoken Language** **Number of children in the family**					
Medicare card number **Expiry Date**		**Name of insurance company (if applicable)**			
Email Address					

CHILD'S HEALTH

Physician Name: _____ **Address:** _____ **Tel.:** _____

Date of last physical examination: _____

Is your child being monitored by his/her doctor? **Yes*** **No**

If yes, please state the reason: _____

Does he/she take medication? **Yes*** **No**

If yes, please state which one(s): _____

Has he/she ever been hospitalized?

Yes* **No**

If yes, please state the reason: _____

ALLERGIES

Penicillin	**Yes**	**No**
Aspirin	**Yes**	**No**
Iodine	**Yes**	**No**
Pollen or dust	**Yes**	**No**
Local anesthetic	**Yes**	**No**

Other: _____

Have any of the following problems been pointed out to you:

Autism spectrum disorder	Yes	No	Eye problems	Yes	No
Heart condition	Yes	No	Abnormal blood tests	Yes	No
Rheumatic fever	Yes	No	Thyroid problems	Yes	No
Sinusitis	Yes	No	Physical handicap	Yes	No
Kidney problems	Yes	No	Prolonged bleeding	Yes	No
Digestive problems	Yes	No	Diabetes	Yes	No
Asthma and/or lung disorder	Yes	No	Attention Deficit or hyperactivity disorder	Yes	No
Hormonal and/or glandular problems	Yes	No	Liver conditions (Hepatitis, cirrhosis, etc..)	Yes	No
Anemia	Yes	No	Learning problems	Yes	No
Mental deficiency	Yes	No	Cerebral palsy or other	Yes	No
Immuno deficiency	Yes	No	Tumor	Yes	No
Malignant hyperthermia	Yes	No	Other: _____		

DENTAL HISTORY

First visit to the dentist: Yes No

Name of previous dentist: _____

Date of last appointment: _____

Treatment received: _____

Referred by: _____

Reason for today's visit:

Injuries (Mouth, head, neck)	Yes	No	Teeth removed	Yes	No
Dental Trauma	Yes	No	Sucks thumb	Yes	No
Bad experience with a dentist	Yes	No	**For Infant or Toddler**		
Mouth breather	Yes	No	Breastfed	Yes	No
Speech problems	Yes	No	Milk bottle	Yes	No
Brushes teeth daily with or without help	Yes	No	Tippy cup	Yes	No
Receives fluoride	Yes	No	Juice bottle	Yes	No
			Pacifier	Yes	No

I declare having read, understood, and answered to the best of my knowledge this medical/dental questionnaire.
Please notify 24 hours in advance if you are unable to keep your appointment. Otherwise, a charge will occur (10$ / 10 minutes)

Signature of parent of guardian: _____ **Date:** _____