half moon
dentistry for children

Dr. N. Vertel Inc.
DDS, MSc, Dip. Ped. Dent, FRCD(C)
Certified Specialist in Pediatric Dentistry

204 - 1656 Martin Drive Surrey BC V4A 6E7
T 604 536 7697 **F** 604 536 7665 **E** info@halfmoondentistry.com
halfmoondentistry.com

Medical-Dental History

Personal History

All of the information which you provided on this form will be held in the strictest confidence. Although some questions may seem unimportant at the time, they may be vital in an emergency situation. Please answer each question and ask if you need assistance completing the form.

Patients Name:_____ Sex: M F

Parents / Guardian:_____

Date of Birth: _____ BC Care Card: _____

Mailing Address:_____

Home Phone: _____ Cell Phone:_____

E-Mail:_____

Purpose of Visit:_____

Family Dentist:_____ Medical Doctor: _____

Referred by:_____

I authorize the doctor to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of information concerning my child's health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actual fee for services. I understand that I am financially responsible for payment in full on all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services provided.

Parent's Signature:_____Date:_____

Dentist's Signature: _____ Date: _____

half moon
dentistry for children

Medical History

1) Is your child under the care of a physician at present? YES NO
If yes, since when and why?
_____

3) Has your child ever had a serious illness or been hospitalized? YES NO
If yes, please

Explain:_____

4) Is your child receiving medication? YES NO
Please list the
medication:_____

5) Is your child allergic to any medication, drugs, or had a bad reaction to any drug, medicine, or food? YES NO

If yes, please list:_____

6) Does your child have any limitations to physical activities? YES NO

If yes, please explain:
_____

7) Does your child have problems: (please circle)

Concentrating Cooperating Learning Understanding None of These

8) Are your child's immunizations up to date? YES NO

10) Does your child have acquired immune deficiency / HIV? YES NO

13) Have you ever been told that your child has/ or has received treatment for any of the following conditions? (please circle any that apply)

Allergy	Anemia	Arthritis	Asthma	Autism	Birth Defects
Bleeding	Brain Injury	Cancer	Cerebral Palsy	Chicken Pox	Child Abuse
Diabetes	Epilepsy	Eyesight Problems	Fainting	Headaches	Hearing Loss
Heart Trouble	Hemophilia	Hepatitis	Hyperactive	Kidney Problems	Latex Allergy
Leukemia	Liver Problems	Lung Problem	Pneumonia	Psychiatric Care	Scarlet Fever
Seizures	Tuberculosis	Developmental Delay	Speech Problems	Nutritional Deficiency	
Blood Transfusions		Emotional Disorders	Cleft Lip/Palate	Developmental Disorder	
High Blood Pressure		Malignant Hyperthermia		Muscular Dystrophy	

14) Other:_____

half moon
dentistry for children

Medical History

1) Has your child had previous dental treatment? YES NO
If so,when?

_____

2) Has your child ever had an unpleasant dental experience? YES NO
If yes, please explain:

_____

3) Have there been any injures to the teeth or mouth? YES NO
If yes, please explain:

_____

4) Does your child have a toothache or other urgent dental problems?
YES NO

_____

5) Was your child referred for / or do you wish (please circle)
Consultation Complete Treatment Specific Problem

6) Is either parent nervous or anxious about their own dental treatment? YES NO

7) Has your child ever received a local anesthetic (freezing) YES NO

Dental Disease Prevention

3) Does your child use dental floss YES NO

4) Does someone assist your child with tooth cleaning YES NO

6) Does your child use a fluoride containing toothpaste? YES NO

8) Does your child eat sweets, drink soft drinks, or juice (please circle)

More than once a day Once per week Less that once per week

9) How does your child receive fluoride? (please circle)

Well water Fluoride drops or tables Fluoride gel or rinses Not at all

10) How was your child fed as an infant? (please circle) Breast Bottle

I attest to the accuracy of the information provided on these 3 pages.

Parent's Signature:_____Date:_____

Dentist's Signature: _____ Date: _____