1540 North Service Road West
Oakville, Ontario
L6M 4A1

P: 905-844-0872
E: office@hunekayedental.com

CHILD REGISTRATION & HEALTH HISTORY

Patient's Name: ______________________________ Date Of Birth: ______________________
(month/day/year)

School: ______________________________

Brother's & Sisters Names & Ages: ______________________________

we collect your email for appointment confirmation purposes only. Please provide us with your email if you wish to confirm your appointment using email

Name of Person Responsible for the Account: ______________________________

Home Address: ______________________ City: ______________ Postal Code: ____________

Home Phone # ______________________ Email: ______________________

Father's Name ______________________ Employed by ______________________

Home Address ______________________ Home Phone # ______________________

City ______________ Postal Code __________ Cell Phone # ______________________

Mother's Name ______________________ Employed by ______________________

Home Address ______________________ Home Phone # ______________________

City ______________ Postal Code __________ Cell Phone # ______________________

Family Physician ______________________ Phone # ______________

Previous Dentist ______________________ Phone# ______________

Reason for Appointment Examination ☐ Orthodontic ☐ Specific Problem ______________________

____

Who May We Thank For Referring You ______________________________

Do You Have Dental Insurance? Yes ☐ No ☐ Name of Person Responsible for This Account ______________________

Do Any Other Family Members Attend This Practice? Yes ☐ No ☐

MEDICAL HISTORY:

Child's Height ______________ Child's Weight ______________

When Did Your Child Last Visit the physician ? ______________ Reason ______________________
(day/month/year)

Have Your Child Ever Been Hospitalized For Any Serious Illness or Surgeries? Yes ☐ No ☐

Reason: ______________________________

____

Does Your Child Have Any Known Medical, Physical or Mental Disability? Yes ☐ No ☐ If So, Describe: ______________________

____

Does your child have any allergies? Yes ☐ No ☐ If So, Describe What It Is and the Reaction: ______________________

____

Has your Child Ever Had An Unfavourable Reaction To: ☐ Penicillin ☐ Other Antibiotic ☐ Cortisone ☐ Local Anesthetic

☐ General Anesthetic ☐ Other Drugs

Is Your Child Presently Taking Any Medication? ______________________________

____

Did Child's Mother Have Any Problems during Pregnancy or Delivery? Yes □ No □
If So, Describe: ____

____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? (If Yes, give Date On Line)

Measles ____________	Asthma ____________	Shortness of Breath ____________	Kidney Disease ____________
Mumps ____________	Hay Fever ____________	Lung Disease ____________	Diabetes ____________
Chicken Pox ____________	Scarlet Fever ____________	Tuberculosis ____________	Gland Trouble ____________
Strep Throat ____________	Rheumatic Fever ____________	Nervous Disorder ____________	Broken Bones ____________
Tonsillitis ____________	Fainting Spells ____________	Epilepsy ____________	Operations ____________
Adenoids ____________	Ear Problems ____________	Liver Disease ____________	Ankle Swelling ____________
Chest Pains ____________	Jaundice ____________	Hepatitis ____________	Physical Deformity ____________
Malignant Hyperthermia ____________	Allergy to Latex ____________	Heart Trouble or Murmur ____________	Other ____________ ____________

Have You Been told that your Child has An Immune Deficiency Syndrome, Aids Related Complex Or A Positive Blood Test For HTLV-111 Virus?
Yes □ No □

DENTAL HISTORY:

Has Your Child Had Previous Dental Care? Yes □ No □ When?________________ For What? ____________________________________
(day/month/year) (day/month/year)

Was There Any Unpleasant Experience Associated With the Dental Treatment? Yes □ No □ If So, Please Describe ___________________________

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Has Your Child Had An Accident or surgery In or Around The Mouth? Yes □ No □
Has Your Child Had Radiation Therapy To The Head or Beck? Yes □ No □
Is There a Family History Of: Missing teeth □ Extra Teeth □ Cleft Lip or Palate □ , Other ____
Does Your Child Have Any of the Following Habits? Thumb sucking □ Finger Sucking □ Previous Soother □ Teeth Grinding □ Lip Biting or Sucking □
Has Your Child Ever Had Any Orthodontic Treatment? Yes □ No □
How Often Does your Child Brush? ____________ Do You Supervise Your Child's brushing Yes □ No □
Does / Has Your Child Received Fluoride Supplements In Diet Or Water Supply? Yes □ No □
Has Your Child Had Decay Preventing Fluoride Treatment? Yes □ No □
Has Your Child Had Fissure Sealant Applications? Yes □ No □

ADDITIONAL INFORMATION:

Is There Any Additional Medical Or Dental Information Which You Feel May Be Helpful In Our Care of Your Child?

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Authorization & Release

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize the qualified dental personnel in this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or diagnostic procedures.

Signature: ________________________________ Print Name:________________________________ Date:____________________
(Patient Parent / Guardian) (day/month/year)