LORNE PARK DENTAL
ASSOCIATES

CONFIDENTIAL PATIENT INFORMATION

Date: _____

Name: _____

Nickname: _____

Address: _____

City: _____ **Postal Code:** _____

Home Telephone: _____

Mother's Name: _____

Father's Name: _____

Mother's Phone: Bus_____

Cell_____

Father's Phone: Bus_____

Cell_____

With which parent does your child live? _____

School: _____ **Grade:** _____

Date of Birth: _____/_____/_____
DAY *MONTH* *YEAR*

How did you hear about us? _____

_____

IN CASE OF EMERGENCY CONTACT:

Name: _____

Telephone: _____

Physician's Name: _____

Physician's Phone: _____

Other Physicians: _____

OTHER DETAILS:

Is your child being treated by other dental specialists? Y / N

Who? _____

Previous Dentist's Name: _____

Previous Dentist's Phone: _____

Do you have dental insurance?* Y / N
**If yes please complete insurance information sheet.*

Please turn page over to continue…

T: (905) 278-5972 F: (905) 278-9155 E: mail@lorneparkdental.com
A: 1151 Lorne Park Road, Mississauga, ON L5H 3A6

MEDICAL HISTORY

1. **Is child now under the care of a physician?** ☐ Yes ☐ No **If yes, please explain:** _____

_____

2. **Has child ever had a serious illness, surgery or been treated in the hospital?** ☐ Yes ☐ No **If yes, please explain:**

_____

3. **Is child now taking any medicine?** ☐ Yes ☐ No **If yes, please provide details:** _____

_____

4. **Is child allergic to any medicine?** ☐ Yes ☐ No **If yes, please list:** _____

_____

5. **Any other allergies?** (eg latex, seasonal, foods) _____

6. **Has child ever had any of the following conditions?**

☐ Measles	☐ Asthma	☐ Heart Trouble	☐ Epilepsy
☐ Mumps	☐ Muscular Dystrophy	☐ Rheumatic Fever	☐ Jaundice
☐ Chicken Pox	☐ Malignant Hyperthermia	☐ Bruise Easily	☐ Kidney Disease
☐ Scarlet Fever	☐ Shortness of Breath	☐ Prolonged Bleeding	☐ Liver Disease
☐ Strep Throat	☐ Lung Disease	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Tonsillitis	☐ Fainting Spells	☐ Cortisone Treatment	☐ Nervous Disorder
☐ Ear Aches	☐ Ankle Swelling	☐ Blood Disease	☐ Exposure to AIDS
☐ Hay Fever	☐ Chest Pains	☐ Diabetes	☐ Other Major Disease

Please explain in full any positive answers: _____

_____

DENTAL HISTORY

1. **Has child had previous dental care?** ☐ Yes ☐ No **If yes, how long ago?** _____

_____

2. **Has child ever had an accident, injury or surgery about the mouth?** ☐ Yes ☐ No **If yes, please describe:**

_____

3. **Is the child nervous about visiting the dentist?** ☐ Yes ☐ No

4. **Has the child ever had an unpleasant experience associated with a dental visit?** ☐ Yes ☐ No **If yes, please explain:**

_____

5. **Have child's teeth ever been treated with fluoride to prevent decay?** ☐ Yes ☐ No

6. **Has child ever had orthodontic treatment?** ☐ Yes ☐ No

7. **Does the child have any habits such as:**

☐ Thumb Sucking	☐ Lip Biting	☐ Nail Biting	☐ Teeth Grinding
☐ Finger Biting	☐ Tongue Thrusting	☐ Mouth Breathing	☐ Other

8. **Is there any family history of:**

☐ High Decay Rate	☐ Extra Teeth	☐ Missing Teeth
☐ Gum Disease	☐ Malformed Teeth	☐ Crooked Teeth

9. **How often does your child brush his / her teeth?** _____ **Use dental floss?** _____

10. **Type of toothpaste used?** _____ **Mouth rinse?** _____

_____

I verify that the above information is accurate. I consent to the performing of dental procedures agreed upon for my child, including the use of local anaesthetic as indicated. I will assume financial responsibility for fees associated with those procedures. I understand that Lorne Park Dental Associates requires 2 business days notice for any change in appointments or a fee may be charged.

Parent Signature: _____
(for child under 18):

Date: _____/_____/_____
DAY *MONTH* *YEAR*