PARKPLACE Junior

Dentistry 4 Kids

Dr. Mary-Anne Svoboda BSc, DDS & Assoc.

PID_____

Last Name: _____ Male or Female Birth Date_____

First Name: _____ Weight: _____lbs/kg Age: _____

Home Address: _____

City: _____ Postal Code _____

Physician Name: _____ Telephone (_____) _____

In Case of Emergency Notify: _____ Relationship: _____

Telephone #: (_____) _____-_____

Parent/Guardian Info:

Name: _____ Relation: _____

DOB: _____Email: _____

Home Ph# (_____) _____-_____ Cell Ph# (_____) _____-_____

Work Ph#: (_____) _____-_____ ext.: _____ (Best Time: _____)

Other Ph#:(_____) _____-_____ Name/Relation: _____

Did you prefer Emails OR Phone reminders? _____

How did you hear about our office? Website□ Sign□

Family/friends/Patient □ -If yes, their name:_____

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www.parkplacejunior.com

Smiles 4 Kids

Medical – Dental History

Is your child in good health?		No	Yes
Is your child's vaccinations up to date?		No	Yes
Is your child under observations or active medical treatment?		No	Yes
Is your child taking any medications – Prescribed or Self-administered? (e.g. aspirins, vitamins)		No	Yes
Does your child tire when climbing a flight of stairs?		No	Yes
Is your child on a medically prescribed diet?		No	Yes
Has your child's weight changed recently?		No	Yes
Does your child have trouble sleeping?		No	Yes
Has your child experienced shortness of breath or chest pain?		No	Yes
Has your child been hospitalized for bleeding or bruising?		No	Yes
Any allergies or adverse reactions to;	a) Penicillin	No	Yes
	b) Aspirin	No	Yes
	c) Other	No	Yes
Has your child been warned against taking any drug or medicine?		No	Yes
Any problems with local anaesthetic (freezing)?		No	Yes
Has your child had general anaesthetic (been put to sleep)?		No	Yes
Has your child taken steroids or cortisone within the last year?		No	Yes
Has your child ever fainted?		No	Yes
Any possibility of being pregnant or planning a pregnancy?		No	Yes
Has your child ever had any serious illnesses or operations?		No	Yes
Does your child wake up at night sweating?		No	Yes
Does your child have trouble healing?		No	Yes

Has your child ever had (or have)?

□ rheumatic fever	□ heart murmurs	□ heart attack	□ heart trouble
□ high blood pressure	□ blood problems	□ anaemia	□ haemophilia
□ kidney trouble	□ liver trouble	□ hepatitis	□ jaundice
□ diabetes	□ thyroid trouble	□ stomach trouble	□ cancer
□ tuberculosis	□ asthma	□ hay-fever	□ lung disease
□ ADD/ADHD	□ Developmental Delay		
□ aids	□ Autism, if yes what Form? _____		
□ other illnesses _____			

What are your present dental concerns? _____

□ bleeding gums	□ crooked teeth	□ broken teeth	□ poor smile
□ loose teeth	□ swollen gums	□ tooth ache	□ missing teeth
□ spaced teeth	□ worn teeth	□ discoloured teeth	

Is there anything else you think you should tell me? _____

Does your family or relatives have any history of serious illnesses? (haemophilia, cancer, diabetes, etc.) No Yes

Date _____ **Signature** _____