

Child Medical History

The staff at Sapperton Dental would like to welcome you to their practice.

To assist us in providing you with the best possible treatment and standard of care, we ask that you complete this confidential medical history questionnaire.

Personal Details:

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City/Postal Code: _____ Phone # _____

Dental History: Are you having any discomfort at this time? If yes please specify: _____

Have you been under the regular care of a dentist? _____

How long since your last dental visit? _____

Medical Information: Medical Doctor/Contact phone #: _____

Are you presently under the care of a medical doctor: If yes please specify: _____

Are you presently taking any medication, including non-prescription, herbal supplements and/or vitamins: _____

Do you have any **allergies** or had any reaction to (medications, anaesthetics, metals, latex, antibiotics etc.): _____

Do you have or have you had any of the following:

High Blood Pressure	Y / N	Anemia	Y / N	Sinus Problem	Y / N	Low Blood Pressure	Y / N
Arthritis	Y / N	Cancer/Chemo	Y / N	Tuberculosis	Y / N	Headaches	Y / N
Thyroid Problems	Y / N	Diabetes	Y / N	Stroke	Y / N	Heart Disease	Y / N
Head/Neck Injuries	Y / N	Hepatitis	Y / N	Chest Pain	Y / N	Blood Disorders	Y / N
Asthma	Y / N	Liver Disease	Y / N	Epilepsy	Y / N	Rheumatic Fever	Y / N
Heart Murmur/Problems	Y / N	Ulcer	Y / N	Emphysema	Y / N	Glaucoma	Y / N

Office Policy : Your appointment time will be reserved especially for you. **If you are unable to keep the appointment we require 48 hours' notice, otherwise, it may be necessary to charge for the time lost.** It is likely that there will be a difference in fees paid by my insurance company and charged by my dentist.

I understand that I am ultimately responsible for the total fees associated with the treatment performed. Including the fees not covered by my insurance. _____ (please initial)

Date: _____ Parent/Guardian Signature: _____