K A L A M U N D A   D E N T A L   C A R E

Paediatric Patient Pre-Treatment Details

Welcome to our Practice! Please answer the following questions as accurately as possible to assist us in our effort to provide the best possible dental care for you. All information provided will be treated with complete professional confidentiality.

Surname: ______________________ First Name: ______________________

Date of Birth: ______________ Gender: Male Female

Address: ______________________________ Postcode: __________

Telephone: (Hm) ______________ (Wk) ______________ (Mob) ______________

Mother's Name: ______________________

Father's Name: ______________________

Person responsible for the payment of your child's account? ______________________

Address ______________________ Phone ______________

Preferred payment method: Cash EFTPOS Credit Card

Is your child covered by a private health fund? Yes No Which fund? __________ How long a member? __________

Who can we thank for your referral to our practice? ______________________

GENERAL HEALTH SUMMARY

- Is your child under the care of a medical doctor? Yes No
  - If Yes, for what condition? ______________________
  - Doctor's Name: ______________________
  - Address: ______________________ Phone: ______________
- Has your child ever been admitted to hospital or had any serious injuries? (Eg. Trauma, illness, falls, fractures) Yes No
  - Please describe: ______________________
- Please list any ***operations*** or surgery your child has undergone: ______________________

  ____
- Please list any ***medications*** your child is currently taking: ______________________

  ____
- Does your child have any ***allergies*** (including medications and latex)? ______________________
- Is there a family history of penicillin allergy or any other serious illness? Yes No
- Are your child's ***immunisations*** up to date? Yes No

Please circle Yes or No for conditions listed below that apply to your child. Please provide additional details in space below.

Condition			Condition		
Heart Disease (Inc congenital heart defects)	Yes	No	High Blood Pressure	Yes	No
Rheumatic Fever	Yes	No	Heart Murmur	Yes	No
Pacemaker	Yes	No	Anaemia	Yes	No
Heart Murmur	Yes	No	Asthma or Bronchitis	Yes	No
Bleeding Disorders (Eg. Haemophilia)	Yes	No	Kidney Disease	Yes	No
Hepatitis or Neonatal Jaundice	Yes	No	Diabetes	Yes	No
Epilepsy or Seizures	Yes	No	Family history of Diabetes	Yes	No
Intellectual disability	Yes	No			

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- Does your child have any condition or problem that is not listed above? Yes No

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PREVIOUS DENTAL HISTORY

- Has your child had any previous dental visits or treatment? Yes No

  If Yes, what treatment has been done? ______________________________

  How did your child cope with the treatment? ______________________________

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- Does your child currently or have they in the past, any of the following habits?
  - Dummy/Pacifier sucking Yes No
  - Thumb-sucking Yes No
  - Bottles before bed Yes No
  - Frequent sipping of juice, cordials or soft drinks Yes No
- Is there a family history of any of the following dental abnormalities or problems?
  - Congenitally missing teeth Yes No
  - Late eruption of teeth Yes No
  - High decay rates Yes No

DIET, GROWTH AND DEVELOPMENT

- Child's Height: _______________ cm
- Child's Weight: _______________ Kg
- Have your child's developmental milestones been: Early Normal Late

  ____
- What is your child's ***quantity*** of sugar consumption? Low Medium High
- What is your child's ***frequency*** of sugar consumption? Low Medium High
- What is your child's main source of drinking water? ______________________________

PREGNANCY HISTORY

- Was your child born: Full-term? Yes No

  Premature? Yes No How much? ___________
- Were there any ante-natal or peri-natal problems? Yes No

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- How was the mother's health during pregnancy? Good Average Poor

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- Is there anything else that we have not asked you that you feel we should know about your child before treating him or her?

  ____

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CONSENT FOR DENTAL TREATMENT (under 16 years of age)

I understand the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any changes to my child's health or medication status on a regular basis.

I hereby authorise the dentist and designated staff to take xrays, study models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs and upon diagnosis I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ any assistance as required to provide proper dental care.

I agree to be responsible for payment of all services rendered on my child's behalf and understand that payment is due at the time of service unless alternative arrangements have been made.

Signature of Parent/Guardian responsible for child: ______________________________

Relationship to child: ______________________________ **Date:** ______________________