PATIENT HISTORY - CHILDREN

Welcome to Cardinia Dental.

The information, of which you provide, is completely confidential and protected by the provisions of the Federal Privacy Law Legislation. Your assistance in completing our acquaintance form assists us to provide to your child, dental care of the highest standard.

Surname:.....**Title: Master □ Mr □ Miss □ Other □** ….....

First Name:.....**Preferred Name:**.....

Date of Birth:...../...../.....

Home Address:.....

Postal Address:.....

Phone Home:.....**Parent's Work:**.....

Mother's Mobile:.....**Father's Mobile:**.....

Email:.....

Preferred Method of Contact: Please Tick: SMS □ Email □ Letter □

Dental Insurance Details: Name of Fund:.....**Number next to child's name:**.....

Medical Doctor:.....**Doctor's Phone Number:**.....

Doctor's Address:.....

Emergency Contact: Name (Person "not" living at your address):.....

Relationship (Friend/Relative etc.):.....**Phone Number:**.....

Address of emergency contact person:.....

Does your child have Ambulance Insurance? YES/NO

Name of person responsible for payment of fees:.....**Relationship:**.....

Whom may we thank for referring you to us?.....

MEDICALHISTORY

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? PLEASE TICK:

Rheumatic Fever	□	**Hepatitis A, B or C**	□	**Asthma**	□
Epilepsy	□	**Aids/HIV**	□	**Heart Ailment**	□
Tuberculosis	□	**Diabetes**	□	**Kidney Disease**	□
High Blood Pressure	□	**Cancer**	□	**Liver Disease**	□
Low Blood Pressure	□	**Excessive Bleeding**	□	**Neck/Back Problems**	□
None of the Above	□				

List any other previous illnesses:.....

Does your child have any allergies? (Please List)......

Is He/She presently under any medical care? (Give Details).....

Please list any medication your child is taking:.....

Does your child have: any prosthetic implants or artificial heart valves? (Give Details).....

Has your child ever had any problems with previous dental visits? YES/NO/FIRST VISIT ….....

THANK YOU FOR YOUR ASSISTANCE

I have completed this questionnaire to the best of my knowledge and understand that failure to make a full disclosure may place my child at undue medical risk, I understand that I am personally responsible for all services rendered and acknowledge that payment is expected on the day of treatment. All overdue accounts will incur a monthly account keeping fee. In the event an overdue account is referred to a debt collection agency I will be responsible for all additional fees and charges.

Sign:..... **Date:**.....

Name:..... **Relationship to child:**.....