PATIENT INFORMATION

TODAY'S DATE _______________

Child's Name ____________________ **Surname:** _________________________ **Age**:______ **D.O.B:**____________

Nickname: _____________________ **Sex M/F:** _____ **Nationality:** _________________________________

Address:____

Contact Tel: (Home)_____________________ (Mum)______________________ (Dad) _______________________

Email: ________________________________**Parents Name – Mum:** _______________ **Dad:** __________________

DENTAL HISTORY: Previous dental care: __________________ When: _____________ Trauma: _______________

Child's response to past medical and dental care? ____

How do you feel your child will behave for dental care? ____

Oral Hygiene: ________________Oral habits (e.g. thumb sucking/"soothers" etc.):________________________________

Referred by ____

Date of last dental visit ____________________ with whom ____

Explain briefly, why you brought your child for dental care ____

MEDICAL HISTORY:

Family physician or Pediatrician ______________________________Address:_________________________________

Date of last medical examination ____

Is your child in good health? ___Yes ____No (explain) ____

Has your child ever had any of the following: (***please tick only where appropriate***)

	A.D.H.D.		Bruising (excessive)		Hemophilia		Respiratory Problems
	Allergies to Anesthetics		Chicken Pox		Hepatitis / Jaundice		Scarlet Fever
	Allergies to Drugs/Medicines		Cold Sores		Kidney /		Sinusitis
	Other Allergies:		Cystic Fibrosis		Liver Involvement		Skin Problems
			Diabetes		Malignancies		Stroke
	Anemia		Dyspraxia		Measles		Typhoid Fever
	Asthma		Epilepsy / Seizures		Mumps		Tonsillitis
	Autism		Fainting / Blackouts		Muscular Problems		Tuberculosis
	Bleeding Disorders		Hay Fever		Nervousness		
	Bronchitis		Heart Problems		Psychiatric Tx		

	Yes	**No**
Is your child presently taking any medication or under active medical care?	___	___
Has your child taken corticosteroids during the past two years?	___	___
Has your child ever been hospitalised? Give details:_______________________________	___	___
____		
Are there any other aspects of your child's health that you think might be important?	___	___
If so please specify: ____		

Do you consider your child to be? (***Please tick one***):

__ advanced in the learning process; __ progressing normally; __ a slow learner

Because your child is a minor, your signature is necessary to give consent for examination, photographs, radiographs (x-rays) & treatment where necessary:

Signed ________________________________ **Print Name** ______________________________ **Date:** __________

Following examination Dr Daly will discuss your child's treatment plan with you

I hereby give consent for treatment as discussed with Dr. Daly

Signed ___________________________________ **Date:** ______________