

**DR. ERROL R. NEZON**  
**Paediatric Dentist**

Welcome to our office. Please complete this form as accurately as possible so that we can provide the best dental care for your child.

**GENERAL INFORMATION**

CHILD'S FULL NAME \_\_\_\_\_ (USUALLY CALLED) \_\_\_\_\_

HOME ADDRESS: STREET \_\_\_\_\_

CITY \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

HOME PHONE NUMBER \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ EMPLOYED BY \_\_\_\_\_ PHONE NUMBER (\_\_\_\_) \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ EMPLOYED BY \_\_\_\_\_ PHONE NUMBER (\_\_\_\_) \_\_\_\_\_

CHILD'S PHYSICIAN / PAEDIATRICIAN \_\_\_\_\_

NAME OF LAST DENTIST SEEN BY YOUR CHILD \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

DENTAL INSURANCE COMPANY NAME \_\_\_\_\_ PLAN MEMBER'S NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ POLICY/GROUP # \_\_\_\_\_ CERTIFICATE/ID NUMBER \_\_\_\_\_

**CHILD'S HISTORY**

AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE OR LEVEL \_\_\_\_\_

FAVOURITE SPORT, HOBBY, TOY, ACTIVITY OR PET \_\_\_\_\_

NAMES AND AGES OF SIBLINGS \_\_\_\_\_

REASON FOR SEEKING DENTAL CARE: i.e. ROUTINE EXAMINATION, TOOTHACHE, ACCIDENT, CROOKED TEETH etc.  
\_\_\_\_\_

**MEDICAL HISTORY**

WHEN DID YOUR CHILD LAST VISIT THE PHYSICIAN AND THE REASON FOR THAT VISIT? \_\_\_\_\_

DID THE MOTHER HAVE ANY PROBLEMS DURING PREGNANCY OR DELIVERY? YES  NO

PLEASE EXPLAIN \_\_\_\_\_

HAS YOUR CHILD EVER HAD A SERIOUS ILLNESS OR BEEN HOSPITALIZED? YES  NO

PLEASE EXPLAIN \_\_\_\_\_

DOES YOUR CHILD HAVE ANY ALLERGIES? YES  NO

PLEASE LIST \_\_\_\_\_

DOES YOUR CHILD BRUISE EASILY OR BLEED EXCESSIVELY WHEN CUT? YES  NO

HAS YOUR CHILD EVER HAD A BLOOD TRANSFUSION OR INTRAVENOUS FLUIDS? YES  NO

IS YOUR CHILD RECEIVING ANY MEDICATION OR DRUGS? YES  NO

PLEASE LIST \_\_\_\_\_

HAS YOUR CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> ANEMIA                      | <input type="checkbox"/> FRACTURES         | <input type="checkbox"/> MALIGNANCIES                |
| <input type="checkbox"/> ASTHMA                      | <input type="checkbox"/> HEADACHES         | <input type="checkbox"/> MEASLES                     |
| <input type="checkbox"/> ATTENTION DISORDER (A.D.D.) | <input type="checkbox"/> HEARING           | <input type="checkbox"/> MONONUCLEOSIS               |
| <input type="checkbox"/> CEREBRAL PALSY              | <input type="checkbox"/> HEART MURMUR      | <input type="checkbox"/> MUMPS                       |
| <input type="checkbox"/> CHICKEN POX                 | <input type="checkbox"/> HEART PROBLEM     | <input type="checkbox"/> RHEUMATIC FEVER             |
| <input type="checkbox"/> DIABETES                    | <input type="checkbox"/> HEPATITIS         | <input type="checkbox"/> SEIZURE DISORDER            |
| <input type="checkbox"/> EAR INFECTIONS              | <input type="checkbox"/> JAUNDICE          | <input type="checkbox"/> SKIN DISEASE                |
| <input type="checkbox"/> EMOTIONAL PROBLEMS          | <input type="checkbox"/> KIDNEY OR BLADDER | <input type="checkbox"/> SPEECH OR LEARNING DISORDER |
| <input type="checkbox"/> EPILEPSY                    | <input type="checkbox"/> LIVER             | <input type="checkbox"/> SURGERY                     |
| <input type="checkbox"/> FAINTING                    | <input type="checkbox"/> LUNG DISEASE      | <input type="checkbox"/> THYROID                     |

**PLEASE PROVIDE ADDITIONAL INFORMATION ABOUT ANY ITEMS THAT WERE INDICATED ABOVE:**

\_\_\_\_\_  
**(OVER PLEASE)**

**DENTAL HISTORY**

IS THIS YOUR CHILD'S FIRST VISIT TO THE DENTIST? YES  NO

DATE OF YOUR CHILD'S LAST VISIT TO A DENTIST? \_\_\_\_\_

WHAT SERVICES WERE PERFORMED THERE? \_\_\_\_\_

AGE AT WHICH THE BOTTLE WAS COMPLETELY STOPPED? \_\_\_\_\_

HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS? YES  NO

PLEASE EXPLAIN \_\_\_\_\_

HAS YOUR CHILD HAD ANY UNHAPPY DENTAL EXPERIENCES? YES  NO

PLEASE EXPLAIN \_\_\_\_\_

HAS YOUR CHILD HAD ANY INJURIES TO THE MOUTH, TEETH OR HEAD? YES  NO

PLEASE EXPLAIN \_\_\_\_\_

DOES YOUR CHILD HAVE ANY ORAL HABITS:

- THUMB OR FINGER SUCKING                       NAIL BITING                       OTHER
- PACIFIER     TEETH GRINDING
- MOUTH BREATHING                               NIGHT TIME BOTTLE

HAS YOUR CHILD HAD ANY ORTHODONTIC TREATMENT? YES  NO

PLEASE EXPLAIN \_\_\_\_\_

IS THERE ANY FAMILY HISTORY OF CROOKED TEETH, MISSING OR EXTRA TEETH, HIGH CAVITY RATE, ETC? YES  NO

PLEASE EXPLAIN \_\_\_\_\_

DOES YOUR CHILD BRUSH HIS/HER TEETH DAILY? YES  NO

DOES SOMEONE ASSIST YOUR CHILD WITH TOOTHBRUSHING? YES  NO

BY WHAT MEANS DOES YOUR CHILD RECEIVE FLUORIDE:

- DRINKING WATER                               TABLETS
- TOOTHPASTE                                       SCHOOL PROGRAMS
- VITAMINS     NONE

IS THERE ANY ADDITIONAL INFORMATION WHICH YOU FEEL MAY BE HELPFUL IN OUR CARE OF YOUR CHILD?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION**

- TO ASSESS YOUR HEALTH NEEDS AND PROVIDE SAFE AND EFFICIENT DENTAL CARE.
- TO ENABLE US TO CONTACT AND MAINTAIN COMMUNICATION WITH YOU TO DISTRIBUTE HEALTH-CARE INFORMATION AND TO BOOK AND CONFIRM APPOINTMENTS.
- TO COMMUNICATE WITH OTHER TREATING HEALTH-CARE PROVIDERS, INCLUDING OTHER DENTISTS, PHYSICIANS, PHARMACISTS AND LAB TECHNICIANS.
- FOR TEACHING AND DEMONSTRATING PURPOSES ON AN ANONYMOUS BASIS.
- TO COMPLETE AND SUBMIT DENTAL CLAIMS FOR THIRD PARTY ADJUDICATION AND PAYMENT.
- TO COMPLY WITH LEGAL AND REGULATORY REQUIREMENTS.
- TO DELIVER YOUR CHARTS AND RECORDS TO THE DENTIST'S INSURANCE CARRIER TO ENABLE THE INSURANCE COMPANY TO ASSESS LIABILITY AND QUANTIFY DAMAGES, AS NECESSARY.
- TO INVOICE FOR GOODS AND SERVICES.
- TO PROCESS CREDIT CARD PAYMENTS.
- TO COLLECT UNPAID ACCOUNTS.

SIGNATURE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ DATE \_\_\_\_\_