Welcome to Arthur St Dental Surgery

Child Medical History

Child #1

Title: Miss, Master

First Name/s:…… Preferred Name: …….

Surname…….

Date of Birth ……/……/…….

Address:……..

Suburb: ……State: ……Postcode: ……

Email:……..

Health Insurance Provider (if any):……. Line Number next to name:…….

Medicare Card Number …….. Line Number next to name:……

1.Parents/ Legal Guardian name/s and **contact numbers**

……

2.Parents/Legal Guardian name/s and **contact numbers**

……

Child #2

Title: Miss, Master

First Name/s:……. Preferred Name: …….

Surname……..

Date of Birth ……/……/……

Health Insurance Provider (if any):……. Line Number next to name:…….

Medicare Card Number …….. Line Number next to name:……

1.Parents/ Legal Guardian name/s and **contact numbers**

……

2.Parents/Legal Guardian name/s and **contact numbers**

……

Have they ever had or are they suffering from any serious illness?

……

<u>Please circle if they have any of the following:</u>

Heart problems Excessive Bleeding Rheumatic Fever Osteoporosis Reflux

Diabetes Asthma Hepatitis HIV/ AIDS

Blood pressure: High/ Low/ Normal

Are they taking any medications (drugs, pills etc) at present (please specify)?

……

Are they allergic to any medications (Penicillin, Codeine, Sulphur, Latex etc)?

……

Do the child/children have any of the following habits? Please circle if applicable & add name

Grinding teeth Mouth Breathing Chewing/Eating problems

Prolonged bottle/pacifier Speech problems Finger/thumb sucking

Do they feel nervous about having dental treatment? If so, what is their biggest concern?.....

Please note any further concerns: ……

……

When was their last visit to the dentist/ How long since their last dental x-rays?

……

How did you hear about us?.....

Consent for Treatment

1. Upon diagnosis, I authorise the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

2. I agree responsible for payment of all services rendered on my behalf and on behalf of my dependants. I understand that payment is due at the time of service.

3. We ask that children attend their treatment appointments without a parent or guardian in the treatment room. Children tend to respond more positively with our dental team without the presence of a parent in the room. This not only can effectively increase your child's confidence but improved communication skills whilst creating fewer distractions within the room, which allows your child to focus more on the treatment and helps to builds trust between your child and our dental team. We understand your child may be anxious, rest assured our team is trained in child-friendly communication and behaviour management.

You are welcome to discuss any concerns with our team beforehand, and for very young or highly anxious children we will always assess on a case-by-case basis.

FULL FEE PAYMENT IS REQUIRED AFTER YOUR APPOINTMENT

PLEASE GIVE US THE COURTESY OF 48(BUSINESS)HRS IF YOU NEED TO RESCHEDULE.

YOUR LATE CANCELLATION MAY ATTRACT A FEE OF $100 AND A DEPOSIT MAY ALSO BE REQUIRED TO SECURE YOUR NEXT DENTAL APPOINTMENT.

Signature……Date ……../……../……

Thank you for your cooperation

All information supplied is for us only (regarding dental treatment) and this is a confidential questionnaire.