



Steven J. Deneka, B.Sc., D.D.S.

Dental Surgeon

Date _____

Child's Name _____

Preferred Name _____

Address _____

City _____

Province _____ Postal Code _____

Home Phone Number _____

Birthdate _____ Age _____

Responsible Parent _____

Occupation _____

Employer _____

Business Address _____

City _____

Business Telephone _____ Ext. _____

Married Single Other

Getting to Know Your Child

How did you hear about our office? _____

Is this your child's first visit to the dentist? _____

Date of your child's last dental visit _____

Does your child have any teeth that are sensitive to hot/cold/sweets to bite on? _____

Does he or she suck their thumb? _____

Has your child ever had any of the following?

- Orthodontic Treatment (braces)?
- Oral Surgery (extractions)?
- Root Canal and /or a Crown?
- Clenching or Grinding problems?
- Bite adjusted?
- Bleeding of their gums when brushing or flossing?
- A negative experience at a dental office?

For Parents

- Do you have your own teeth? Yes No
- Do you brush your child's teeth Yes No
- Does your water contain fluoride? Yes No

Present Physicians' Name _____

Address _____ Phone# _____

Has your child been under medical care in the past 2 years? _____

Is your child now taking any medication, drugs or pills? _____

If yes, please list: _____

Has your child had an adverse reaction to any medications? _____

Chart #: _____

Does your child have or have they ever had any of the following?

- Y N**
- Artificial Heart Valve
 - Heart Pacemaker
 - Heart Surgery
 - Asthma
 - High Blood Pressure
 - Heart Murmur
 - Rheumatic Fever
 - Malignant Hyperthermia (or a family history of)
 - Epilepsy or Seizures
 - Fainting or Dizzy Spells
 - Bruise Easily
 - Diabetes: Diet or medication controlled?
 - Hepatitis A (infectious)
 - Hepatitis B (serum)
 - HIV Positive
 - Has anyone suggested your child needs pre-medication prior to dental treatment?
 - Consent for Nitrous Oxide when necessary?
 - Are you concerned about the precautions this office takes regarding infectious diseases?

Dental Insurance **Yes** **No**

Primary Insurance Company _____

Secondary Insurance Company _____

Your Spouse

Occupation _____

Employer _____

Business Address _____

City _____

Business Telephone _____ Ext. _____

Office Policies Reviewed:

- Financial Arrangements
- Appointments
- Philosophy of our practice

Parent's Signature (for child under 18 years) _____ **Date** _____

I understand that the above questions directly relate to the quality of dental care I can expect to receive in this office. I have not knowingly withheld information that could complicate my treatment.