sappertondental
FAMILY & COSMETIC DENTISTRY

Child Medical History

The staff at Sapperton Dental would like to welcome you to their practice.
To assist us in providing you with the best possible treatment and standard of care, we ask that you complete this confidential medical history questionnaire.

Personal Details:

Name: _____ Date of Birth: _____Age: _____

Address: _____City_____ Postal Code: _____

Phone Home#_____Cell #_____ Email_____

Insurance Company_____ Policy#_____ ID#_____

Policy Holder's name: _____Date of Birth of Policy Holder: _____

Dental History: Are you having any discomfort at this time? If yes please specify:_____

Have you been under the regular care of a dentist?_____

How long since your last dental visit?_____

Medical Information: Medical Doctor/Contact phone #:_____

Are you presently under the care of a medical doctor: If yes please specify:_____

Are you presently taking any medication, including non-prescription, herbal supplements and/or vitamins:_____

Do you have any **allergies** or had any reaction to (medications,anaesthetics, metals,latex, antibiotics etc.):_____

Do you have or have you had any of the following:

High Blood Pressure	Y / N	Anemia	Y / N	Sinus Problem	Y / N	Low Blood Pressure	Y / N
Arthritis	Y / N	Cancer/Chemo	Y / N	Tuberculosis	Y / N	Headaches	Y / N
Thyroid Problems	Y / N	Diabetes	Y / N	Stroke	Y / N	Heart Disease	Y / N
Head/Neck Injuries	Y / N	Hepatitis	Y / N	Chest Pain	Y / N	Blood Disorders	Y / N
Asthma	Y / N	Liver Disease	Y / N	Epilepsy	Y / N	Rheumatic Fever	Y / N
Heart Murmur/Problems	Y / N	Ulcer	Y / N	Emphysema	Y / N	Glaucoma	Y / N

Office Policy :Your appointment time will be reserved especially for you. If you are unable to keep the appointment we require two business days notice, otherwise, it may be necessary to charge for the time lost.
_____***Please initial***

The dentist shall obtain my verbal consent before performing any dental procedure. I understand that I am ultimately responsible for the total fees associated with the treatment performed this is including the fees not covered by my insurance policy _____Please initial.

Parent/Guardian Signature:_____ **Date:**_____

Parent/Guardian Print Name:_____

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