RUSSELL LEA DENTAL CARE

230 Lyons Road
Rusell Lea NSW 2046

MEDICAL AND DENTAL HISTORY FORM FOR CHILD/YOUTH

Parent/Guardian Name: ……

Given Name (s) : ……Surname: …… F / M

Preferred Name: …… Date of Birth: ……..

Home address: ……

Postcode: …… School: ……..

Health Fund: ……..Medicare Number: …… Ref.Number : ……

Is your child eligible for the Child Dental Benefits Scheme? YES …… NO …….

Phone No. (H) : …….. (W): ……

(M): …… Email: ……

(Your appointment confirmation will be sent out via email)

What is the main reason for your visit to Russell Lea Dental Care?: ……

……

Whom may be thank for our referral to Russell Lea Dental care? : ……..

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MEDICAL,DENTAL AND SLEEP HISTORY

Please tick any symptoms or conditions that apply to your child

…..Frequent Infections	…..Asthma	…… Heart Disorders
…..Allergies	…..Neurological Conditions	….. Bleeding Disorders
…..Digestive Problems	…..Diabetes	…..Compromise Immune System
…..Epilepsy	…..Breathing Problems	….. Mouth Breathing
…..Enlarged Tonsils/Adenoids	…..Dark circles under eyes	…..Restless Sleep
…..Snoring	…..Gasping or choking during sleep	…..Wakes frequently at night
…..Tired during the day	…..Learning and behavioural issues	…..Lack of concentration at school
…..Night sweats	….. Postural problems	…..Thumb sucking
…..Narrow palate	….. Bed wetting	…..Headaches
…..Clicking or popping of TMJ	…..Ear problems	…..Teeth grinding or clenching
…..Tongue Tie	….. Speech difficulties	……Crowded/crooked teeth

…..Missing teeth ……Spaces forming between teeth ……Decayed teeth

…..Infected teeth ……Teeth tender to chew on …..Teeth sensitive to hot,cold,sweet

…..Bleeding or discomfort of gums ……Change of colour in teeth …..Food catching between teeth

…..Swelling or lumps present ……Change in appearance in face ….. Bad breath

…..Other ……..

Any allergies to Medication? If so, please state: ……

Current Medication/Supplements: ……..

……..

Current Medical Practitioner: ……

How long has it been since your child's last dental appointment: ……

Were the teeth (please tick): ….Examined ……X-rayed …..Cleaned at that time?

Significant past dental treatment: ……

Do they use the following products ? How often?

-Toothbrush …… Floss …….. Other……

What toothpaste do they usually use?: ……

Do you have any concerns about their dental treatment? : ……

THANK YOU

Financial Terms

1- Payment is expected at the time of your dental visit unless prior financial arrangements have been made with the dentist. Payment may be made by cash,cheque,Bankcard,Mastercard or Visa. We have a HICAPS facility for most Health Funds.
2- Faile appointments or failing to give 24 hours notice of a cancellation will incur a fee, the amount depending on the length of the appointment.

Patient/Parent Signature: …….. Date: ……..