Dependent Child Health Questionnaire

In an effort to make your visit a positive experience we ask that you complete the following questionnaire to help us get to know your child before their appointment.

Name: _____**Preferred Pronouns:**_____

Date of Birth: (d/m/y)_____ **Gender at birth:**_____

Parent/Guardian Name(s): _____

Siblings (with ages):_____

Address:_____

Contact Phone/Cell:_____**Email:** _____

Physician: _____ **Pharmacy:** _____

Health Card Number:

1. Is your child experiencing any dental concerns at this time? If so, please explain:

2. Is this your child's first dental visit/experience? ☐ **Yes** **No** ☐

If no, would you consider your child's previous dental experiences to have been:

Positive? Negative? Successful? Unsuccessful? (Circle one, and please explain)

☐ ☐ ☐ ☐

4. For any reason, has your child ever had:

Local Anesthesia (dental "freezing")? ☐ **Yes** **No** ☐

Sedation ("laughing gas" or sedative medicine)? ☐ **Yes** **No** ☐

General Anesthesia (ie: for an operation)? ☐ **Yes** **No** ☐

5. What is your child's regular dental hygiene routine? Brush? Floss? How often per day?

6. Do they brush on their own or assisted by parent/ guardian? ☐ **Own** **Assisted** ☐☐

7. Does your child use a toothpaste containing fluoride? ☐ **Yes** **No** ☐

8. Please describe any **current** medical issues/disorders/diseases or concerns:

9. Please describe any **past** childhood illnesses or past medical experiences?
(including if they were positive or negative):

9. Does your child have **allergies,** adverse reactions, or sensitivities? ☐ **Yes** **No** ☐
(e.g. penicillin, sulfa drugs, latex, metals, foods etc.?) If yes, please list:

Is your child taking any **medications**, supplements, or vitamins/minerals ☐ **Yes** **No** ☐
If yes, please include medication name, dose, frequency:

Is there anything else you feel we should know about your child?

_____ _____

Signature of parent/guardian Date (d/m/y)