**Centre Dentaire Schwartz & Associés**
**6200, rue Saint-Denis**
**Montréal, QC H2S 2R7**
**514-270-1523**

## GENERAL INFORMATION

Family Name____________________________________ First Name______________________________
Date of Birth_____________Gender M F Other Medicare Card Number___________________________
Address______________________________City__________________ Prov. ____Postal Code__________
Home phone _________________Cell phone________________ Email_____________________________
Father's name_____________________________ Mother's name_________________________________
Employer________________________________ Employer _____________________________________
Name of child's medical doctor_____________________________ Phone number____________________

## MEDICAL HISTORY

Is the child currently being treated by a medical doctor for anything? Yes___ No___
Has he/she ever had a serious illness? (see below) Yes___ No ___
Has he/she ever been treated in a hospital? Yes___ No ___
Operations____________________________________________________ Yes ___ No ___
Is he/she taking any medications regularly? Yes___ No ___
if yes, which ones? ____________________________________________
Does he/she have any allergies? Yes ___ No ___
if yes, to what?
Has he/she ever had a bad reaction to any medical or dental treatment? Yes ___ No ___
Has the child ever had any of the following illnesses?
Chicken pox___ Mumps ___ Measles ___ Scarlet Fever ___
Tonsillitis ___ Diabetes ___ Epilepsie ___ Jaundice ___ Tuberculosis ___
Liver disease ___ Kidney disease ___
Ear infections or pain ___ Hay fever ___ Respiratory distress ___ Lung disease ___
Swollen Ankles ___ Chest pains ___ Angina ___ (other) Heart Problems___
Frequent bruising (Hematomas) ___ Blood diseases/disorders ___ Prolonged bleeding ___
Acute Rheumatoid Arthritis ___ Nervous disorders/ problems ___

# Dental History

Has the child already had dental treatments? Yes ___ No ___
If yes, when? ____________________________________
Has he/she ever had an accident or injury involving the mouth? Yes ___ No ___
When and how? ________________________________________
Has he/she ever had any surgery of the mouth Yes __ No ___
When? for what? ________________________________________
Has the child ever had a bad experience when visiting a dentist? Yes ___ No ___
Has he/she ever had preventive Fluoride treatment for cavities (even in school) Yes ___ No ___
Has he/she ever had orthodontic treatment (braces)? Yes ___ No ___
Has the child any of the following bad habits
Thumb sucking ___ Finger sucking ___
Lip Biting ___ Nail biting ___
Breathing through mouth ___ Grinding teeth (especially at night) ___
Other (please tell us what) __________________________

Is there a history in the families (both mother's and father's) of

Supranumary teeth (extra teeth!) Yes ___ No ___
Missing teeth Yes ___ No ___
Crowded teeth Yes ___ No ___
Protruding teeth Yes ___ No ___

Date______________________ Parent's signature ________________________________________

Dentist's signature ________________________________________