KETTLE VALLEY FAMILY DENTAL

103-5315 Main St
Kelowna, British Columbia, V1W 4V3
(778) 477-0411

We are pleased you have chosen us for your child's dental care!

Patient's Name:________________________Preferred Name:________________Date of Birth:__________________

Parent's/Guardian's Name:_____________________________________Relationship to Patient:_________________

Please circle all that apply:

Anemia	Chicken Pox	Heart Problems	Mononucleosis
Arthritis	Chronis Sinusitis	Hepatitis	Mumps
Asthma	Diabetes	HIV/AIDS	Rheumatic Fever
Bladder Problems	Ear Aches	Immunizations	Seizures
Bleeding Disorders	Epilepsy	Kidney Problems	Sickle Cell
Bone/Joint Problems	Fainting	Latex Allergy	Thyroid (Low/High)
Cancer	Growth Problems	Liver Problems	Tuberculosis (TB)
Cerebral Palsy	Hearing Problems	Measles	Other

If other circled, please list: ____

Please circle corresponding answer:

1. Is your child taking any prescription and/or over the counter medications or vitamin supplements at this time. Yes / No

If yes, please list:____

2. Is your child allergic to any medications, i.e. Penicillin, Antibiotics, or other drugs? Yes / No

If yes, please list:____

3. Is your child allergic to anything else, such as certain foods? Yes / No

If yes, please list:____

4. Has your child ever had a serious illness? Yes / No

If yes, please list:____

5. Has your child ever been hospitalized? Yes / No

If yes, please list:____

6. Does your child have a history of any other illnesses? Yes / No

If yes, please list:____

Initial: _______________

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7. Does your child experience excessive bleeding when cut? Yes / No

8. Is this your child's first visit to a dentist? Yes / No

If not the first visit, what was the date of the last dentist visit? ____________________

9. Has your child ever had any problems with dental treatment in the past? Yes / No

10. Has your child ever had dental radiographs (x-rays)? Yes / No

11. Has your child ever suffered any injuries to the mouth, head or teeth? Yes / No

12. Is fluoride toothpaste used? Yes / No

13. What type of water dose your child drink? City Water Well Water Bottles Water Filtered Water

14. How many times a day are your child's teeth brushed?__________When are teeth brushed?__________

15. Do you still assist with brushing your child's teeth? Yes / No

16. Is your child in any orthodontics appliance or braces? Yes / No

HOW DID YOU HEAR ABOUT OUR CLINIC? WE WOULD LOVE TO KNOW! ____________________

Parent/Guardian Signature:____________________Date:____________________