

Welcome to our practice. The following information is requested to enable us to give your child our best attention. All questions and consultations are treated with confidentiality.



Patient Details

Name:				
Date of Birth:	/	/	Gender:	Male/Female
Address:				
Phone:		Work:		
Mobile:				
Parent/Guardian:				
Private Insurance:	HOSPITAL COVER:	Yes/No	DENTAL COVER:	Yes/No
Medical Practitioner:				
Who referred you to our practice:				

Patient Medical History

Please tick if your child has ever been diagnosed with any of the following?

Heart murmur/surgery	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Sensory impairment	<input type="checkbox"/>
Liver disease (hepatitis)	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Autism/Asperger's Syndrome	<input type="checkbox"/>
Childhood arthritis	<input type="checkbox"/>	Gastrointestinal diseases	<input type="checkbox"/>	Learning or developmental delay	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Creutzfeldt-Jacob Disease	<input type="checkbox"/>
Cleft /clefting condition	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

Is your child's immunization up to date?

Yes/No

Has your child ever had a general anaesthetic or sedation?

Yes/No

Has your child ever suffered from any other significant illness or been diagnosed with a congenital or developmental anomaly? (Please list)

Please list any medications or dietary supplements (eg vitamins) your child is currently taking?

Please list any allergies your child has (eg latex, food & medicines)?

Reason for seeking care

Routine examination	<input type="checkbox"/>	Referral from Dentist	<input type="checkbox"/>	Past difficult experience	<input type="checkbox"/>
Dental trauma	<input type="checkbox"/>	Dental pain/infection	<input type="checkbox"/>	Other	<input type="checkbox"/>

The information provided in this document is true and correct to the best of my knowledge at the time of signing and I am also aware of Newcastle Paediatric Dental Service's Privacy Policy.

Signed: _____ Date: _____