Welcome to Tottenham Village Dentistry

Please Tell Us About Your Child

First Name: _____ **Last Name:** _____ **Nickname:** _____
Date of Birth: _____ **Home Phone:** _____
Address: _____ **City:** _____ **Postal Code:** _____
School: **Grade:**

Please Tell Us About Yourself

Parent / Guardian Full Name: _____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____
Email Address: _____ **Occupation:** _____
Insurance Carrier: **Group Number:**

Please check box if your child has had any of the following			
AIDS or HIV		Heart Disease	
Anemia		Heart Murmur	
Artificial Heart Valves		Hepatitis	
Asthma		Kidney Disease	
Bleeding Problems		Liver Disease	
Chicken Pox		Lung Disease	
Diabetes		Mental / Nervous Disorder	
Earaches		Mumps	
Eating Disorders		Sight Problems	
Epilepsy / Seizures		Stomach Problems	
Hearing Problems		Tuberculosis	
Other:			

Please Select "Yes" or "No" to Each Question	Yes	No
Have you ever been advised that your child should take antibiotics before dental treatment?		
Do your child carry epinephrine?		
Has your child ever been treated for cancer?		
If "Yes", what type?		
Does your child have a family history of Malignant Hyperthermia?		
Has your child had an unusual reaction to local / general anesthetic or nitrous oxide?		
Has the child had any previous surgery?		
If "Yes", what type?		
Has your child ever had any reactions to medications?		
If "Yes", which medications?		

List Any Current Medications:	
List Any Allergies:	

Family Physician:	
Specialist Physician:	

Dental History	
How did you hear about us?	
What brings you to see us today?	
Has the child had previous dental care?	
If yes, how long ago?	
Has the child had dental x-rays?	
If yes, how long ago?	
Has the child been complaining about dental pain?	
Is there anything you liked or disliked about your child's previous dental office?	
What is important to you in your child's dental office?	
Is there anything else you would like us to know?	

Parental Consent

I hereby consent to the preforming of dental and oral surgery procedures necessary or advisable for my child.

Parent's Signature: _____ Date: _____

TOTTENHAM VILLAGE Dentistry