Ayr Dental

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PATIENT CHART

Name ______________________________ Date of Birth ______________________________

Address ______________________________ Home Phone ______________________________

______________________________ Email ______________________________

City ______________________________

Parent's Name ______________________________ Cell Phone ______________________________

Physician ______________________________ Telephone ______________________________

QUESTIONNAIRE

1. When was your child's last dental visit? ______________________________
2. Has your child ever experienced any unusual reaction to any drugs or medicines? .... ☐ Yes ☐ No

   To what? i.e. Penicillin ______________________________
3. Is your child under care of a physician now? .... ☐ Yes ☐ No
4. Are they presently taking any medicines or tablets? .... ☐ Yes ☐ No

   If so, what? ______________________________
5. Does your child have any allergic conditions? (e.g. Hay fever, asthma rash, other) .... ☐ Yes ☐ No

   Please list: ______________________________
6. Has your child had heart disease or murmur? .... ☐ Yes ☐ No
7. Does your child have or have had any of the following:

☐ Heart trouble	☐ Kidney trouble	☐ Epilepsy	☐ Asthma	☐ AIDS
☐ High blood pressure	☐ Liver trouble	☐ Thyroid trouble	☐ Blood disorders	☐ Other ______________
☐ Rheumatic fever	☐ Diabetes	☐ Tuberculosis	☐ Anaemia	______________

PERMIT FOR OPERATIONS

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anaesthetic as indicated and I will assume full responsibility for fees associated with those procedures.

Patient (Parent, Guardian) Signature ______________________________ Date ______________

Comments

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