Surname:_____ **First:**_____ **Gender:**_____

Date of Birth:_____ **Nationality:** _____ **Languages:**_____

Phone No: _____ **Email Address:**_____

BSN for Children (under 18yrs) – with Dutch Insurance _____

Dental Hygiene

How often does your child brush their teeth? _____

Does your child brush their teeth alone or does someone help them : _____

Type of toothbrush: Manual Electric (Brand and type : _____ **)**

What toothpaste are they using ? _____

Do they use any of the following and at what frequency:
dental floss tooth picks interdental brushes other_____

Today's visit is for a consultation (Intake) and X-rays - please list any dental issues you would like to discuss with the dentist:
_____

Last dental appointment: _____ **Country:**_____

Last X-rays:_____ **List if known: – Bitewings - PA/Solo - Panoramic/OPT.**
(Please email previous X-rays and dental records to ihchdental@ezorg.nl to be placed in your file)

Health History

What does your child drink on daily basis and at what frequency? _____

What type and how often is their sugar intake (chocolate, sweets, cookies, fruit juice, sodas, milk etc…) :
_____

Currently under medical treatment: YES / NO Please explain:_____

Has your child ever been hospitalized for any surgical operation or serious illness within the last 5 years? Please explain:
_____

Is your child taking any medication, including non-prescription medicine? YES / NO

Please list medications:_____

Are they allergic to any of the following? YES / NO

◯ Aspirin ◯ Penicillin ◯ Local Anesthetics ◯ Any metal ◯ Latex

◯ Other If yes, please explain:_____

Does your child clench or grind their teeth?	◯ **Yes**	◯ **No**
Do your child's gums bleed while brushing or flossing?	◯ **Yes**	◯ **No**
Does your child have any broken tooth?	◯ **Yes**	◯ **No**
Are your child's teeth sensitive to hot or cold liquids/food?	◯ **Yes**	◯ **No**

Are your child's teeth sensitive to sweet or sour liquids/food? ◯ **Yes** ◯ **No**

Does your child feel pain to any of their teeth? ◯ **Yes** ◯ **No**

If yes, please explain where/which kind of pain**:** _____

Does your child experience any of the following problems in their jaw?

Clicking ◯ **Yes** ◯ **No**

Pain (joint, ear, side of face) ◯ **Yes** ◯ **No**

Difficulty opening or closing ◯ **Yes** ◯ **No**

Difficulty in chewing ◯ **Yes** ◯ **No**

Does your child have frequent headaches? ◯ **Yes** ◯ **No**

Did your child ever have any difficult extractions in the past? ◯ **Yes** ◯ **No**

Did your child ever have any prolonged bleeding following extractions? ◯ **Yes** ◯ **No**

Does your child wear dentures, dental prosthesis or an ortho appliance? ◯ **Yes** ◯ **No**

Did your child and yourself ever receive oral hygiene instructions regarding the care of your teeth and gums?
◯ **Yes** ◯ **No**

Please indicate if your child ever had any of the following conditions:

◯ **High Blood Pressure**
◯ **Heart Attack**
◯ **Rheumatic Fever**
◯ **Fainting/Seizures**
◯ **Asthma**
◯ **Low Blood Pressure**
◯ **Epilepsy/Convulsions**
◯ **Leukaemia**
◯ **Digestive Disorders**
◯ **Kidney Disease**
◯ **AIDS/HIV Infection**
◯ **Thyroid Problems**

◯ **Heart Disease**
◯ **Anaemia**
◯ **Frequently Tired**
◯ **Cancer**
◯ **Arthritis**
◯ **Joint Replacement/ Implant**
◯ **Hepatitis type** _____
◯ **Diabetes**
◯ **Respiratory Problems**
◯ **Chest Pains**
◯ **Stroke**
◯ **Tuberculosis**

◯ **Liver disease**
◯ **Glaucoma**
◯ **Mental health disorder :**
_____
◯ **Other**
_____
_____

I have answered the questions to the best of my knowledge. I understand that withholding pertinent information may affect a full diagnosis. It is my responsibility to inform the dental office of any changes in my medical status. I give permission for the IHCH Dental Clinic to record my personal data and health history until further notice.

I understand that if I miss an appointment or decide to cancel with less than 24hrs notice, I will be charged a fee

I understand that Payment is due at time of service for all patients *(exception is children under 18yrs with proof of Dutch dental insurance coverage).*

_____ _____

Signature of Patient, Parent or Guardian **Date**