*LIVERPOOL* **SPECIALIST KIDS DENTIST** *SUMMER HILL*

**Dr Chinh Nguyen & Associates** *File no.*

**Specialist Paediatric Dentist**

## Child's Details

**Last name**_____ **First name**_____ M/F_____

Preferred name _____ **Date of Birth**_____

**Address**_____ Suburb_____ P/Code_____

## RESPONSIBLE PARTY

**GUARDIAN 1/DAD** _____
(Mr,Ms,Miss,Mrs)

Address (if different)_____

_____

Home Phone_____

Occupation_____

Mobile _____

**GUARDIAN 2/ MUM** _____
(Mr,Ms,Miss,Mrs)

Address (if different) _____

_____

Home Phone_____

Occupation_____

Mobile _____

**Marital Status**: ☐Married ☐ Separated ☐Divorced ☐ Single ☐ Widowed

**Email Address**:

## Other siblings in the family (Name & age)

**Emergency contact name if parents cannot be contacted**

Name_____ Phone No_____ Relationship _____

**Health Insurance Details / Medicare Details**

**Health Insurance Fund Name** _____ **Member No**._____ **Patient No**.____

Hospital Cover (please circle): Yes No

Dental Cover (please circle): Yes No

**Medicare number** _____

**Eligible for Child Dental Benefit Schedule**: Yes / No

**Referring Doctor/Dentist Details**

Name of referring Doctor / Dentist

If not referred, how did you hear about us?

**DENTAL HABITS**

**When Breast feeding stopped:** _____ **Night feeding habits:** _____

**Thumb sucking: YES / NO**

**Pacifier use: YES / NO**

**YOUR CHILD'S MEDICAL HISTORY**

Name of regular Family Dentist_____

Name of regular Medical Doctor_____

Name of Specialist Doctors_____

1. Is your child in good health? □YES □NO
   Explain_____

2. Are antibiotics necessary for dental work because of a heart mumur, heart defect, prosthesis, shunt, or other medical reason? □YES □NO

3. Has your child ever been hospitalized? Had Operations? Suffered a prolonged illness or disability? Received irradiation or chemotherapy? □YES □NO
   Explain (when? What reason?)_____

4. List any known ALLERGIES or ADVERSE REACTIONS to medicine/food/substance e.g. Penicillin, milk, Latex

| Medicine name/Food | Nature of reaction | How long ago |
|---|---|---|
| | | |
| | | |

5. Is your child taking any medications (tablets, pills etc) now? □YES □NO
   Specify_____

6. Has your child had all the immunizations recommended by the NSW Health Department? □YES □NO

   Specify_____

7. Has you child recently had a toothache? **□YES □NO**
   Specify_____

**Has your child ever had or presently have any of the following:** □ Nil known

□ History Rheumatic Fever □ Asthma □ Pre-Mature Birth □ Cerebral Palsy
□ Heart murmur/Defect □ Respiratory Problems □ Syndrome □ Epilepsy
□ Tuberculosis □ Thyroid Problems □ Cleft Lip/Palate □ Mental Disability
□ Liver Problem or Hepatitis □ Diabetes □ Speech Difficulty □ Autism
□ Gastrointestinal Problems □ Kidney Problems □ Cancer □ ADHD
□ Excess bleeding problems after tooth extractions, cuts or injuries. □ Significant problems with general anaesthesia □HIV
□ Adverse response to dental treatment
□ Others (specify)

If yes to any of the above, give details:

**I hereby certify that to the best of my knowledge, the foregoing information is correct. As my child is a minor:**

1. **I give my consent for their examination and treatment.**
2. **I am responsible for any financial obligations incurred for my child's treatment, and also for incidental costs incurred, and/or legal fees necessary to recover the same.**
3. **I understand that the account is to be finalized on the day of the treatment or unless alternative arrangements have been made with SPECIALIST KIDS DENTIST and that interest may be charged on overdue accounts.**
4. **I understand that I must provide 24 hours notice for cancellations otherwise I will be liable for a cancellation fee ($150 per 30mins appointment).**

**Parent/Guardian Signature**_____ **Date**_____/_____/_____

**Name (Please PRINT)** _____