International Health Centre The Hague

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 Disease**	◯ **Liver disease**
◯ **Heart Attack**	◯ **Anaemia**	◯ **Glaucoma**
◯ **Rheumatic Fever**	◯ **Frequently Tired**	◯ **Other**
◯ **Fainting/Seizures**	◯ **Cancer**	____________________
◯ **Asthma**	◯ **Arthritis**	____________________
◯ **Low Blood Pressure**	◯ **Joint Replacement/ Implant**	____________________
◯ **Epilepsy/Convulsions**	◯ **Hepatitis type** ___________	
◯ **Leukaemia**	◯ **Diabetes**	
◯ **Digestive Disorders**	◯ **Respiratory Problems**	
◯ **Kidney Disease**	◯ **Chest Pains**	
◯ **AIDS/HIV Infection**	◯ **Stroke**	
◯ **Thyroid Problems**	◯ **Tuberculosis**	

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**