Patient Information

Name: ___________________________________ Gender: M F

Nickname: ___________________________	Phone : (____) ____________________
Birth Date: ________________	Address:____________________________
Age: ____________	City: ______________________________
School/ Grade: __________________________	Province: ______ Postal Code: _______
E-Mail:_______________________________	Preferred Contact: Home / Mobile / Email

Who may we thank for referring you? ________________________________

Your relationship with patient: __________________

Do you have legal custody of child? Yes No

Parent I	**Parent II**
Name: ____________________________	Name: ______________________________
Work #: (______)_________ ext _______	Work #: (______)_________ ext _______
Home #: (______)______________________	Home #: (______)______________________
Cell #: (______)______________________	Cell #: (______)______________________
E-Mail:_______________________________	E-Mail:_______________________________
Employer:____________________________	Employer: ___________________________

Care Card No. ______________________________ **Status No.** ______________________________

Previous Dentist: ______________________________ **Telephone:** ______________________________

Last Cleaning Date: ______________________________ **Last X-ray Date:** ______________________________

Dental Insurance: Yes No

Dental Insurance First Coverage	
Employee: ______________________________	Birth Date: ___________________________
Employer:_______________________________	Insurance Company:___________________
Subscriber ID/Certificate #: _________________________	Group/Policy #:_________________________
Coverage: _____________%	Recall Coverage: Every _______months

Dental Insurance Second Coverage	
Employee: ______________________________	Birth Date: ___________________________
Employer:_______________________________	Insurance Company:___________________
Subscriber ID/Certificate #: _________________________	Group/Policy #:_________________________
Coverage: _____________%	Recall Coverage: Every _______months

I authorize the release of information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual fee for services. I understand that I am financially responsible for payments in full on all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, inwhole or in part by my dental care payor.

Signature _________________________ Name__________________________Date _____________

Medical History

Name of physician: __________________ Phone: __________________

Address: ____

Does your child have a health problem? Yes No if yes please explain ______________________

____

Please list any medications that your child is taking

____

Is your child allergic to any medicine, drugs, or food? Yes No if yes please list

____

Does your child have any limitations to physical activities? Yes No If yes please explain

____

Has your child ever had any of the following medical problems?

Heart/ Blood/ Circulatory	Y N	Cancer	Y N
Lung	Y N	Nervous System	Y N
Digestive/ Stomach/ Intestine	Y N	Kidney/ Bladder	Y N
Endocrine	Y N	Muscles	Y N
Immune System	Y N	Skin	Y N
Ears/ Tonsils/ Adenoids	Y N	Bones	Y N
Eyes	Y N	Liver	Y N

For other illnesses that is not mentioned above, please explain: ________________________

____

Is your child up-to-date with vaccination? Yes No

Dental History

Reason for today's visit: ____

Is your child in any pain today? Yes No

if yes please explain____

Has your child ever had dental treatment? Yes No if yes when?________________________

Has your child ever had an unpleasant dental experience? Yes No if yes please explain.

____

How do you think your child will behave on today's dental visit? ______________________________

What can we do to make today's visit more pleasant for your child?______________________________

Has there been any injury to the teeth or mouth? Yes No if yes please explain.

____

How often does your child brush teeth? ____

How often does your child floss? ____

Does someone assist your child when brushing/ flossing? Yes No if yes, how cooperative is your child when brushing/flossing? ____

Does your child use fluoride containing toothpaste? Yes No

Does your child eat between meals? Yes No if yes how often? ________________________

Does your child have any oral habits such as thumb/finger sucking? Yes No

I authorize the dental staff to perform the necessary dental services my child may need. The information given is correct to the best of my knowledge, and I understand that this information will be held in the strictest of confidence. I understand that it is my responsibility to inform this office of any changes in my child's health status.

Signature __________________________ Name___________________________Date _____________