

PATIENT INFORMATION FORM PEDIATRIC AND ADOLESCENT PATIENTS

The information requested below is very important. Please make it as complete and accurate as possible because it will help us to provide the best possible health service. This information form becomes part of our permanent records and will be held in strictest confidence. For parents of children, complete this information for your child. Please circle YES or NO on the yes and no questions. Thank you.

PERSONAL

DATE _____

1. Name _____ M / F
Last First
2. Date of Birth _____ / _____ / _____ Age of Patient _____
Day Month Year
3. Home Address _____
Street
City Province Postal Code
4. Telephone No. _____

5. Person responsible for child's account:

Parent #1

Parent #2

- | | |
|---|---|
| Name _____ M / F
Last First | Name _____ M / F
Last First |
| Email _____ | Email _____ |
| Mobile _____ Work _____ | Mobile _____ Work _____ |
| Date of Birth _____ / _____ / _____
Day Month Year | Date of Birth _____ / _____ / _____
Day Month Year |

DENTAL INSURANCE INFORMATION

Parent #1

Parent #2

- | | |
|---------------------------------|---------------------------------|
| Employer _____ | Employer _____ |
| Name of Insurance company _____ | Name of Insurance company _____ |
| Id. Number _____ | Id. Number _____ |
| Policy Number _____ | Policy Number _____ |

MEDICAL

1. Name of the Patient's Physician _____ Telephone No. _____
2. Has the child or adolescent ever been hospitalized since birth? YES NO
At what age(s) and for what reason(s) _____
3. Is a physician treating the child or adolescent at this time? YES NO
If yes, for what reason? _____
4. Is the child or adolescent taking any medicine at this time? YES NO
If yes, what is he/she taking? _____



5. Does the child or adolescent have any history of allergies? (check if applicable)

☐ Hay Fever

☐ Penicillin

☐ Asthma

☐ Sulfa Drugs

☐ Local Anaesthetics

☐ Other

YES

NO

Explain

6. If the patient has any history of the following, please check which one(s):

☐ Hearing Difficulties

☐ Kidney disease

☐ Speech Difficulties

☐ Epilepsy or seizures

☐ Emotional Difficulties

☐ Cerebral palsy

☐ Poor Vision

☐ Anaemia

☐ Liver disease or hepatitis

☐ Birth defects

☐ Diabetes

☐ Heart problems

☐ Bleeding problems

☐ Sickle cell anemia

☐ Asthma or wheezing

☐ There is NO history of these problems

☐ Rheumatic fever

☐ Other

DENTAL

1. Please check the reason(s) for seeking dental care:

☐ New examination

☐ Appearance of teeth/ crowding

☐ Accident to teeth

☐ Toothache

☐ Other (specify)

2. Has the child or adolescent ever been to the dentist?

YES

NO

If yes, was it:

☐ Your family dentist

☐ A specialist - Name

3. Have you been pleased with the child's or adolescent's previous dental care?

YES

NO

If no, please comment:

4. Have the teeth of the child or adolescent ever been injured?

YES

NO

What was the cause of the accident?

How old was the patient?

Which teeth were involved?

5. Has the child or adolescent had any unfavourable experiences in a dental or medical office?

YES

NO

If yes, please describe:

6. Name of School

Grade

OTHER

1. Whom may we thank for referring you to us?

2. Hobbies or pets of child

3. Is there any other information you believe would be helpful to us?

YES

NO

If yes, please comment:

Signature of parent or guardian

Date

Relation to child or adolescent