Patient Information Form

Welcome to My Dental Home. We are glad you are here. Should you have any questions please feel free contact us at mydentalhome@rogers.com or 905-415-7700

NAME: _____ PREFERRED NAME: _____

ADDRESS: _____

CITY: _____ PROV.: _____ POSTAL CODE: _____

HOME PHONE: _____ Parent BUS. PH: _____ CELL: _____

Parent EMAIL: _____

DATE OF BIRTH: _____ Parent Driver's Licence #: _____
MM/DD/YY

PERSON RESPONSIBLE FOR ACCOUNT: _____

EMPLOYED BY: _____

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

IN CASE OF AN EMERGENCY PLEASE CONTACT:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

DENTAL BENEFITS INFORMATION

POLICY HOLDER: _____ DATE OF BIRTH: _____

EMPLOYER NAME: _____ SIN: _____

INSURANCE CARRIER: _____

POLICY/GROUP #: _____ CERTIFICATE #: _____

☐ **Yes/No**

POLICY HOLDER: _____ DATE OF BIRTH: _____

EMPLOYER NAME: _____ SIN: _____

INSURANCE CARRIER: _____

POLICY/GROUP #: _____ CERTIFICATE #: _____

I AUTHORIZE RELEASE TO MY INSURANCE COMPANY/PLAN ADMINISTRATOR,
THE INFORMATION CONTAIND IN CLAIMS SUBMITTED ELECTRONICALLY.

_____ _____
Signed Date

OVER

HEALTH HISTORY

Please read and answer Y or N to each of the following as they apply to your child:

___ Allergies (seasonal)	___ Dizziness	___ High/Low Blood Pressure	___ Rheumatic Fever
___ Anemia	___ Drug Addiction	___ HIV Positive	___ Rheumatism
___ Arthritis	___ Emphysema	___ Jaw Joint Pain	___ Scarlet Fever
___ Artificial Heart Valve	___ Excessive Bleeding	___ Kidney Disease	___ Seizures
___ Artificial Joints	___ Fainting	___ Liver Disease/Jaundice	___ Sinus Problems
___ Asthma	___ Glaucoma	___ Mitral Valve Prolapse	___ Stomach Problems
___ Blood Disease	___ Heart Conditions	___ Nervousness/Depression	___ Stroke
___ Bruise Easily	___ Heart Lesions	___ Pacemaker	___ Thyroid Disease
___ Cancer	___ Heart Murmur	___ Respiratory Problems	___ Tuberculosis
___ Chemotherapy	___ Heart Surgery	___ Radiation (head/neck)	___ Ulcers
___ Diabetes	___ Hepatitis A B C		

Does your child have any of the following allergies:

___ Aspirin	___ metal/jewelry	___ Codeine	___ Penicillin
___ Latex	___ Sulfa	___ Erythromycin	___ Other:_____

Have you ever been instructed to give your child antibiotics prior to dental care? _____

Is your child under a physician's care:

Routine Care: _____

Specific Conditions: _____

Is your child taking any medications: _____

I allow my child's medical doctor to be consulted if necessary.

Physician's Name: _____ Phone: _____

Questionnaire:

1 Tell me how you care for your infant/child's Teeth. _____

_____

2 Does your child use a bottle ? Yes/ No. If NO please go to Question 3

Name all the products you fill the bottle with: _____

How often a day does your infant/child have with the bottle? _____

Is the bottle given: At night: Duration: _____ (minutes) or all night: _____ (hours)

Day: as per schedule Y N or "at will" _____

3 Is your child breast fed? How often a day does your infant/child breast feed:

At night: Duration: _____ (minutes) or all night: _____ (hours)

Day: as per schedule Y N or "at will" _____

4 Does your child use a sippy cup?

How often a day does your child have a sippy cup? _____

Or is the sippy cup used "at will": Y N

5 List the most common snacks consumed by your infant/child: _____

_____

6 Does the infant/child's parent(s), siblings or caregivers have decay or unresolved dental issues? Y N

7 Is there fluoride in your tap water? Y N

8 Please circle any habits: Pacifer thumb sucking finger biting

Grinding/clenching mouth breathing

Other: _____

9 Are you aware of snoring and/or difficultly breathing during sleep? Y N

10 Are you aware of any injuries to the teeth or gums? Y N

11 What concerns you the most about your infant/child's dental health? _____

_____

The above personal and medical history for my child is complete and accurate, and I have not knowingly withheld information. I authorize the dentist to perform diagnostic procedures and administer treatment. I will be presented with options and allowed to ask questions. I understand that responsibility for payment for all procedures during treatment is mine.

_____ _____ _____

Signature Date Dr. Initials