Medical Information for Children

Patient Name _____
Birth Date _____
Parent/Guardian Home Ph (___)_____ Work Ph (___)_____ Cell Ph (___)_____
Address _____
City _____ Postal Code _____
Email _____
Name of Physician _____ Phone # (___)_____

Insurance Information

Name of Policy Holder _____ Birth Date _____
Policy Holder's Employer _____
Name of Insurance Company _____ Group/Policy # _____ ID# _____

Secondary Insurance

Name of Policy Holder _____ Birth Date _____
Policy Holder's Employer _____
Name of Insurance Company _____ Group/Policy # _____ ID# _____

When did your child last receive Dental Treatment? _____

Has your child had any unfavourable experiences in a dental or medical office? Yes No

Does your child have any of the following habits, which might affect the teeth or mouth?

Breathe through mouth	Yes No	Sucks thumb or fingers	Yes No	Bites fingernails	Yes No
Grinds Teeth	Yes No	Thrusts tongue	Yes No	Pacifier	Yes No

Has your child had any of the following?

Measles	Yes No	Cold Sores	Yes No	German Measles	Yes No
Canker Sores	Yes No	Chicken Pox	Yes No	Mumps	Yes No
Mononucleosis	Yes No	Thrush	Yes No	Hepatitis	Yes No

Has your child ever been hospitalized? Yes No
Where, When, Why?_____

Is your child presently on medication? Yes No
Type/Name, Dosage, Reason _____

Has a Cardiologist or your Family Doctor informed you of your child's need to be placed on a prophylactic antibiotic coverage prior to any dental procedures? _____

Has your child had history of….

Allergies:	Food	Yes No	Bleeding disorder	Yes No
	Drugs (antibiotics, analgesics)	Yes No	Asthma	Yes No
	Pollen	Yes No	Cystic Fibrosis	Yes No
Heart Disease:				
	Rheumatic Fever	Yes No	Gastro-Intestinal Disorder	Yes No
	Congenital	Yes No	Diabetes Type I	Yes No
Liver:	Jaundice	Yes No	Diabetes Type II	Yes No
	Immune Disorder	Yes No		
Urinary Disorder:				
	Bladder	Yes No		
	Kidney	Yes No		

Because your child is a minor, it becomes necessary that a signed permission be obtained from a Parent or Guardian before any and/or all necessary services can be started. Authorization is hereby granted as such. I understand that prior to treatment, a full explanation of procedures and fees for same will be given by the Doctor and/or their staff. I agree to pay for all services rendered by this office.

Date _____ Signature (Parent/Guardian) _____