PATIENT INFORMATION FORM
PEDIATRIC AND ADOLESCENT PATIENTS

Date of Record _____

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

1. Name _____ M or F _____
2. Date of Birth _____ Age of patient _____ years _____ months
3. Home Address: Street _____

   City _____ Prov. _____ Postal Code _____
4. Telephone No.: Res:_____
5. **Person responsible for child's account:**

   Name_____
6. Father - First Name_____ Mother - First Name _____

   Occupation _____ Occupation _____

   Employer_____ Employer_____

   Business No._____ Business No._____

   Date of Birth _____ Date of Birth _____

DENTAL INSURANCE INFORMATION

Employed (See "A") Social Services (See "B") Other (specify)_____

A. Employer _____

   Name of Insurance Company _____
   D M Y

   Subscriber's Date of Birth_____

   Id. Number _____ Policy Number_____

B. Current card must be presented at each appointment

   Name of Card Holder _____

   File # _____

   Patient Name_____

   File # _____

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 medicines 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)_____ YES NO

   ☐ Hay Fever ☐ Penicillin ☐ Asthma

   ☐ Sulfa Drugs ☐ Local Anaesthetics ☐ Other

   Explain _____

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

- ☐ Hearing difficulties
- ☐ Speech difficulties
- ☐ Emotional difficulties
- ☐ Poor vision
- ☐ Liver disease or hepatitis
- ☐ Diabetes
- ☐ Bleeding problems
- ☐ Asthma or wheezing
- ☐ Rheumatic fever
- ☐ Kidney disease
- ☐ Epilepsy or seizures
- ☐ Cerebral palsy
- ☐ Anemia
- ☐ Birth defects _____
- ☐ Heart problems _____
- ☐ Sickle cell anemia
- ☐ There is NO history of any of these problems
- ☐ Other _____

DENTAL

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

- ☐ New examination
- ☐ Toothache
- ☐ Appearance of teeth/ crowding
- ☐ Accident to teeth
- ☐ 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 unfavorable experience 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 that you believe would be helpful to us? YES NO

   If yes, please comment: _____

   _____

Signature of parent or guardian _____ Date _____

Relation to child or adolescent _____