Child Information

First Name: _____ Last Name: _____ Preferred Name: _____

Date of Birth: _____(DD) _____(MM) _____(YYYY)

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Mobile Phone: _____ Email Address: _____

Emergency Contact Name: _____ Phone Number: _____ Relationship: _____

Primary Insurance Carrier: _____ Policy#: _____ ID# _____

Secondary Insurance Carrier _____ Policy# _____ ID# _____

Secondary Holder Name: _____ Secondary Holder DOB: _____

Child Dental Health History

Date of last dental exam: _____ Date of last hygiene: _____ Date of last x-rays: _____

Does your child have an immediate dental concern? _____

Has your child had any unfavorable dental experiences? _____

How often does your child brush their teeth? Twice a day ☐ Once a day ☐ Sometimes ☐ Never ☐

How often does your child floss? Twice a day ☐ Once a day ☐ Sometimes ☐ Never ☐

Does your child have any of the following: (Please check all that apply)

☐ Thumb/Finger Sucking
☐ Pacifier
☐ Nursing/Bottle
☐Bites/Chews Objects
☐ Mouth Breathing
☐ Snoring

Any other habits/concerns you wish to discuss? _____

Child Medical Health History

Medical Doctor: _____ Phone Number: _____ Date of Last Visit: _____

Does your child have any allergies? _____

List all medications your child is currently taking: _____

Please check all that apply:

☐ Abnormal Bleeding
☐ ADHD
☐ Asthma
☐ Behavioral Concerns
☐ Congenital Heart Defect
☐ Developmental Delays
☐ Diabetes
☐ Epilepsy/Seizures
☐ Hearing Impairment
☐ Heart Murmur
☐ Hepatitis
☐ HIV/AIDs
☐ Nervous Disorders
☐ Rheumatic Fever
☐ Speech Disorder
☐ Tuberculosis

Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilize all personal information in a responsible and professional manner. This document summarizes the personal information we collect, use and disclose. In addition; we collect, use and disclose personal information when permitted or required by law.

Contact information is collected and used for the following purposes:

- To open and update patient files
- To invoice patients for dental services, to process credit card payment or to collect balances owing
- To process dental claims for reimbursement from third-party health benefit providers on behalf of patients'
- To send reminders to patient concerning the need for further dental treatment or reminders via text or email
- To send patient information about our dental practice

Patients' Medical Information May be disclosed to:

- Third-party health benefit providers for reimbursement of claims or estimates
- To other dentists or specialists, if the patient, with their consent, has been referred by our dentists for treatment
- To other dentists or specialists, where a second opinion may be required
- To other healthcare professionals such as physicians, if the patient, with their consent, has been referred to us, or by us to another healthcare professional

Patient Name: _____ Signature: _____ Parent/Guardian: _____