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? ____

Authorization and Release
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all records of any treatment or examination rendered to me or my child during the period of such dental care to services rendered on my behalf or my dependents. I authorize the dentist to submit my insurance claims electronically on my behalf.

X ____ Date ________________________________
Signature of patient (or guardian if minor)