

**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 CONTAINED 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:

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

Does your child have any of the following allergies:

- |                                  |  |                                       |                                       |
|----------------------------------|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> metal/jewelry | <input type="checkbox"/> Codeine      | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Latex   | <input type="checkbox"/> Sulfa         | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> 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