WOODBRIDGE KIDS Dentistry
www.woodbridgekids.com

PATIENT INFORMATION

PATIENT

FIRST & MIDDLE NAME: ____________________

LAST NAME: ____________________

PREFERRED NAME: ____________________

☐ MALE ☐ FEMALE

ADDRESS:

STREET: ____________________

CITY: ____________________

POSTAL CODE ________ ________ Box #: ____________

HOME PHONE NUMBER: ______-_________-____________

PREFERRED CONTACT METHOD: ____________________

DATE OF BIRTH: ________ ________ ______
MONTH DAY YEAR

REFERRED BY: ____________________

FAMILY MEDICAL DOCTOR: ____________________

PHONE NUMBER: ________-__________-_____________

OTHER INFORMATION:

NAMES OF BROTHERS /SISTERS	AGE	PATIENTS OF THIS OFFICE? YES	NO
____________________	_______	☐	☐
____________________	_______	☐	☐
____________________	_______	☐	☐

PARENT/GUARDIAN INFORMATION

MOTHER/GUARDIAN

FIRST NAME: ____________________ ☐ MS ☐ MRS

LAST NAME: ____________________

Same As Patient ☐**If different, fill information below**

ADDRESS:

STREET: ____________________

CITY: ____________________

POSTAL CODE ________ ________ Box #: ____________

WORK NUMBER: ______-___-_____-___________ EXT. _______

HOME: PHONE NUMBER: ____-______-_______

CELL NUMBER: ____-______-_______

EMAIL ADDRESS ____________________

FATHER/GUARDIAN

FIRST NAME: ____________________

LAST NAME: ____________________

Same As Patient ☐ **If different, fill information below**

ADDRESS: STREET: ____________________

CITY: ____________________

POSTAL CODE ________ ________ Box #: ____________

WORK NUMBER: _______-_________-__________ EXT. ______

HOME: PHONE NUMBER: ______-_________-__________

CELL NUMBER: ______-_________-__________

EMAIL ADDRESS ____________________

INSURANCE COVERAGE

DENTAL COVERAGE **(✓one of the following)**

☐ INSURANCE proceed to INSURANCE INFORMATION below)

☐ NO INSURANCE

☐ CHILDREN'S AID

☐ ONTARIO WORKS (please provide monthly card)

☐ CINOT

☐ ODSP (please provide monthly card)

☐ HSO (please provide yearly card)

INSURANCE INFORMATION

FATHER/GUARDIAN

EMPLOYER ____________________

INSURANCE CARRIER ____________________

PLAN POLICY NUMBER ________________ DIV. NO. ________

CERTIFICATE/SIN NUMBER ____________________

DATE OF BIRTH: ____________________DD/MM/YY

RECALL FREQUENCY ☐ 6 mo. ☐ 9 mo. ☐ 12 mo.

MOTHER/GUARDIAN

EMPLOYER ____________________

INSURANCE CARRIER ____________________

PLAN POLICY NUMBER ________________ DIV. NO. ______

CERTIFICATE/SIN NUMBER ____________________

DATE OF BIRTH: ____________________DD/MM/YY

RECALL FREQUENCY ☐ 6 mo. ☐ 9 mo. ☐ 12 mo .

PLEASE TURN OVER

PLEASE ANSWER THE FOLLOWING QUESTIONS AND PROVIDE DETAILS (If Yes, please explain)	Yes	No
1. Has your child ever had any serious illness?		
2. Has your child ever been hospitalized or had a major operation?		
3. Were there any complications surrounding the pregnancy or birth of your child?		
4. Has your child ever had prolonged bleeding following a tooth extraction or minor injury?		
5. Has your child ever had a skin reaction or itching after using rubber objects such as balloons,gloves etc.? If yes, which one(s)? ______________________________________		
6. Does your child have allergies i.e. any drug, medication, general anaesthetic, environmental allergies, or foods etc? If yes, which one(s)? ______________________________________		

7. Does your child have or has he/she ever had any of the following? **If No, leave blank.**

	Check if Yes ✓		Check if Yes ✓		Check if Yes ✓
Infectious Disease (AIDS, TB)		Diabetes		High/Low blood pressure	
Arthritis		Emotional disorder		Jaundice	
Asthma		Epilepsy		Family history of malignant hyperthermia	
Bladder/Kidney disease		Fainting spells		Mental disorder	
Blood disorder(s)		Any handicap condition		Respiratory disease	
Cleft lip/palate		Heart disease/ murmur/ rheumatic fever		Special schooling	
Cerebral Palsy		Hearing disorder		Speech problem	
		Hepatitis/Liver disease		Thyroid problem	
Other: (Please state)					

PRESENT STATE OF HEALTH

Is your child:		Check if Yes ✓
	presently in good health?	
	currently under medical care?	
	taking or has he/she taken any medication in the last six months?	
Please list current medications (incl. non-prescription, herbal supplements):		

BEHAVIORAL BACKGROUND

1. Do you consider your child to be ☐ hyperactive ☐ advanced in learning process ☐ progressing normally ☐ slow learning
2. How do you expect your child to behave in the dental chair? ☐ very well ☐ moderately well ☐ poorly
3. Has your child had an unfavourable dental/medical experience in the past? ☐ yes ☐ no
   If yes, please explain.

DENTAL HISTORY

1. Has your child ever damaged his/her mouth/jaw? ☐ yes ☐no
   If yes, please explain.
2. Does your child have any oral habits ☐ thumb sucking ☐ finger sucking ☐lip sucking ☐ pacifier ☐ lip biting ☐ grinding of the teeth

GENERAL INFORMATION

1. What is your child most interested in? ____
2. What does your child especially dislike? ____
3. Any additional information which you think is pertinent? ____
4. Person (other than parent/guardian) to contact in case of an emergency

NAME: ________________________________ **PHONE NUMBER**: _____ - _________ - __________

RELATIONSHIP: ____

I verify that the above information is correct.

Date ____________________ **Parent/Guardian signature**____________________________________