WELCOME TO OUR OFFICE!

For your benefit, please have this form completed and bring it with you to your first visit.

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____

POSTAL CODE: _____ PHONE#: _____ WORK#: _____

☐ Male ☐ Female REFERRED BY: _____ DENTIST: _____

INSURANCE: ☐ Yes ☐ No ☐ Dual

RESPONSIBLE PARTY:

Mother's Name: _____ and **Father's Name:** _____

Address: (if different from above) _____

City: _____ Postal Code: _____ Work #: _____

* EMAIL ADDRESS: _____

Is any other family member a patient at our office? ☐ No ☐ Yes: _____

Reason for seeking treatment: _____

MEDICAL HISTORY:

Patient's Medical Doctor: _____

Has the patient ever had any of the following illnesses?

☐ Rheumatic Fever	☐ Asthma	☐ Angina	☐ Psychiatric Care
☐ Hepatitis	☐ TB	☐ Heart Disease	☐ Autism Spectrum
☐ Jaundice	☐ Scarlet Fever	☐ Thyroid Problem	☐ Emotional Disturbances
☐ Diabetes	☐ Mononucleosis	☐ Malignant Hyperthermia	☐ Learning Difficulties

1. Is the child taking any medication? ☐ No ☐ Yes: _____
2. Is the child allergic to any medication or food? ☐ No ☐ Yes: _____
3. Is there anything in the patient's medical history that the dentist should be aware of?
   ☐ No ☐ Yes: _____
4. We desire the very best result possible for your child. Is there any issue that might affect their ability to follow instructions for brushing, flossing, elastic wear or wearing appliances? (ie. difficulties with learning, co-ordination or manual dexterity?) ☐ No ☐ Yes: _____

DENTAL HISTORY:

1. Has the child ever had an orthodontic consultation or treatment? _____
2. Does the child have any oral habits such as:
   ☐ Thumb Sucking ☐ Nail Biting
   ☐ Finger Sucking ☐ Mouth Breathing
   ☐ Tongue Thrusting ☐ Teeth Grinding
3. How often does the patient brush their teeth? ☐ None ☐ 1-2x/day ☐ 3-4x/day ☐ 4-5x/day

DATE: _____ **SIGNATURE**: _____

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