Biographical (Child)

Patient Name: _____ Age:_____
Date of Birth:_____ Sex (Circle one): M or F
Family Dentist: _____

Parents: Mom: _____ Dad: _____

Address: _____ Address: _____

_____Postal Code_____ _____Postal Code_____

Phone: _____ (H)_____(C) Phone: _____(H)_____(C)
_____ (W) _____(W)

If parents are separated or divorced, please indicate if both parents are permitted access to appointment and treatment information. Yes No

When confirming appointments, we can contact you by ONE of the following: telephone, text message or email. Which do you prefer? Phone# _____
Text Message#_____ Email address: _____

Clicking Jaw Joint Yes No Teeth or Jaw injuries/accidents Yes No
Locking Jaw Yes No
Do you have any habits such as biting nails, sucking your thumb, etc? If yes please specify:

_____

Have you ever had any of the following?
Rheumatic Fever? Yes No Hepatitis? Yes No
Abnormal heart conditions? Yes No Diabetes? Yes No
Abnormal bleeding from cuts? Yes No
Allergies? Please Specify: _____
Have you had any medical conditions in the past? If yes, please specify: _____

_____
Are you currently taking any prescription or non-prescription medications? Yes No

How did you find out about our office? (circle which ones apply)
Dentist / Friend / Family
Advertisement: TV / Radio / Newspaper / Yellow Pages / Other_____

Has anyone in your family had braces in this office? If yes, please name:_____

What concerns you the most about your teeth?_____

Insurance Information

Insurance company: _____
Name of Holder: _____
Birth Date: _____
Policy/Group #: _____
Certificate/ID #: _____
Employer: _____

First Nations Inuit Health Benefits ONLY

Treaty #: _____
Band Name and Phone #: