



REFERRED BY

dentist family doctor other

First name:

Last name:

Welcome to Werb Dentistry! Please fill in the entire form to the best of your knowledge. If you have any questions, please feel free to ask any one of our friendly staff members. All information is strictly private and is protected by doctor-patient confidentiality.

Child/Patient Information

First Name:

Last Name:

Nickname:

Date of Birth:

Gender: Female Male

Street:

Apartment #:

City:

Postal Code:

Home Phone #:

INSURANCE INFORMATION

No insurance. Group/private insurance. (Please fill out insurance info below.) CINOT (Please provide claim form.) Ontario Works (Please provide benefit card.) Other (please specify):

SIBLINGS

Names of Brothers/Sisters					
Age					
Patients of this office?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

PLEASE FILL OUT THE BACK OF THIS FORM.

Guardian/Mother

First name:

Last Name:

Date of Birth:

Cell phone #:

Work #:

Email Address:

ADDRESS

Same as patient.
 Different from patient (please indicate)

Street:

City:

Postal Code:

Home phone #:

INSURANCE

Employer:

Insurance Carrier:

Plan #/Group #:

ID/Cert. #:

Teeth cleaning covered every: 6mos 9mos 12mos Unsure

Guardian/Father

First name:

Last Name:

Date of Birth:

Cell phone #:

Work #:

Email Address:

ADDRESS

Same as patient.
 Different from patient (please indicate)

Street:

City:

Postal Code:

Home phone #:

INSURANCE

Employer:

Insurance Carrier:

Plan #/Group #:

ID/Cert. #:

Teeth cleaning covered every: 6mos 9mos 12mos Unsure

Patient Name:

DENTAL HISTORY

1. Has your child ever damaged his/her mouth or jaw?

- Yes
 No

If yes, please explain:

2. Does your child have any oral habits? Yes. No.

- thumb sucking pacifier
 finger sucking lip biting
 lip sucking grinding of teeth

BEHAVIORAL BACKGROUND

1. Do you consider your child to be

- Hyperactive Progressing normally
 Advanced in learning Slow in learning

2. How do you expect your child to behave in the dental chair?

- Very well
 Moderately well
 Poorly

3. Has your child ever had an unfavorable dental/medical experience in the past?

- Yes
 No

If yes, please explain:

GENERAL INFORMATION

1. What is your child most interested in?

2. What does your child especially dislike?

3. Any additional information you think is pertinent?

EMERGENCY CONTACT

An individual who will NOT be present at appointments.

Name:

Relationship to patient:

Phone #:

I verify the information on this form is correct to the best of my knowledge.

Date:

Signature:

Yes No Maybe

1 Is your child being treated for any medical conditions at the present, or have they been treated within the past year?
2 When was your child's last medical check up?
3 Has there been any change in your child's general health in the past year?
4 Is your child taking any medications, non-prescription drugs, or herbal supplements of any kind?
5 Has your child ever been hospitalized or had a major operation?
6 Were there any complications surrounding the pregnancy OR birth of your child?
7 Has your child, or anyone in your family, ever had a peculiar or adverse reaction to any medications or injections?
8 Does your child have any allergies? If yes, please specify:
8a. Medications
8b. Latex/rubber
8c. Other (eg. hayfever, foods)
9 Does your child have, or have they ever had, any of the following?
Autism Spectrum Disorder, Epilepsy, Malignant hyperthermia, Arthritis, Fainting spells, Mental disability, Asthma, Heart disease/murmur, Physical disability, Bladder/kidney disease, Infectious disease (HIV, TB), Respiratory disease, Blood disorder(s), Hearing disorder, Rheumatic fever, Cleft lip/palate, Hepatitis/liver disease, Special schooling, Cerebral palsy, High/low blood pressure, Speech problem, Diabetes, Jaundice, Thyroid problems, Others: