Welcome to our Office!

Please take a few minutes to provide us with the following important information

Patient name:_____

Home address:_____

City: _____ Prov: _____

Postal Code: _____

Home Phone: _____

D.O.B: _____ Age:_____ M or F

Dentist: _____

School: _____

Family Information

The following is requested so that we can communicate properly with the people involved in your child's treatment.

Parents are married separated divorced remarried

Child lives with parents mother father other

Other Adults we should know about? NO

Other Name: _____

Relationship to child: _____

Phone (H): _____ (C): _____

Other Name: _____

Relationship to child: _____

Phone (H): _____(C): _____

Dental Information
Please check the box if your child has one/any of the following:

- ☐ **Clicking jaw**
- ☐ **Locking jaw**
- ☐ **Biting nails**
- ☐ **Thumb/finger sucking**
- ☐ **Accident/Injury to teeth or jaws**

What concerns you about your teeth/smile? Please specify:

_____

Mother's name:_____

Home address:_____

City: _____ Prov: _____

Postal Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Father's name:_____

Home address:_____

City: _____ Prov: _____

Postal Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Medical Information
Please check the box if your child has one/any of the following:

- ☐ **Rheumatic Fever**
- ☐ **Diabetes**
- ☐ **Kidney Problem**
- ☐ **Heart conditions**
- ☐ **Stomach problems**
- ☐ **Thyroid disorder**
- ☐ **Hepatitis/Liver problems**
- ☐ **Bone disorder**
- ☐ **Abnormal bleeding/bleeding disorder**

☐ **Allergies to medications, metals or other. Please specify** _____

☐ **Is there any past or present medical condition not listed above?** _____

☐ **Does your child smoke? How much?** _____

☐ **Is your child currently taking any prescription medication?** _____

How did you find us?
Indicate the top reason for coming here (1) and the other ways you heard about our office (2)

1 or 2 Referred by dentist

1 or 2 Referred by family or friend

1 or 2 Family member was/is being treated by Dr. Bales (name) _____

1 or 2 Recommended by other patient/parents (name)_____

1 or 2 Heard about us through school, community activity, etc

1 or 2 Web site

1 or 2 Team member

1 or 2 Yellow pages or Phone Book

1 or 2 Radio advertisement

1 or 2 Other advertisement _____

Insurance Information

	Mom	**Dad**
Insurance Company:	_____	_____
D.O.B.	_____	_____
Policy or Group #	_____	_____
Certificate or ID #	_____	_____
Employer:	_____	_____

	Stepmother (if applicable)	**Stepfather (if applicable)**
Insurance Company:	_____	_____
D.O.B.	_____	_____
Policy or Group #	_____	_____
Certificate or ID #	_____	_____
Employer:	_____	_____

First Canadian Health Benefits Treaty Number: _____