Fitzgerald
DENTISTRY

WE ARE PLEASED TO WELCOME YOU AND YOUR CHILD TO OUR PRACTICE. PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS COMPLETELY AS YOU CAN. IF YOU HAVE QUESTIONS WE'LL BE GLAD TO HELP YOU. WE LOOK FORWARD TO WORKING WITH YOUR CHILD.

PERSONAL INFORMATION

☐MST ☐MISS ☐MX

Name_____ _____
Last Name First Name Preferred Name, if different from first

Date of Birth _____ Age _____ Email_____

Address _____ _____ _____ _____ _____ _____
Unit Number Street City Province Postal Code

Preferred Phone _____ Alternate Phone _____
☐ home ☐work ☐cell ☐home ☐ work ☐cell

School _____ Grade _____ Hobbies/Sports _____

Emergency Contact _____ Phone _____

Whom may we thank for referring you? _____

Do other members of your family see us? _____

ACCOUNT INFORMATION

Person responsible for account_____ _____
Last Name First Name

Address _____ _____ _____ _____ _____ _____
Unit Number Street City Province Postal Code

Preferred Phone _____ Alternate Phone _____
☐ home ☐work ☐cell ☐home ☐ work ☐cell

Do you have dental insurance ☐ Yes ☐No? If yes, please complete the following information so we may prepare claim forms or electronically submit claim forms for you.

Name of Subscriber _____ Relationship to Subscriber _____

Name of Insurance Company _____ Plan # _____

ID # _____ Subscriber Date of Birth _____

For secondary insurance, please complete the following:

Name of Subscriber _____ Relationship to Subscriber _____

Name of Insurance Company _____ Plan # _____

ID # _____ Subscriber Date of Birth _____

PLEASE CONTINUE ON REVERSE SIDE. THANK YOU

DENTAL INFORMATION

What is the name of your child's previous dentist? _____ When was their last dental checkup? _____

Did their previous dentist take any x-rays? If so, when? ☐ Y ☐ N _____

How often does your child brush? _____ How often does your child floss? _____

Child's habits affecting the mouth or teeth: ☐ Thumb sucking ☐ Nail biting ☐ Other:_____

Other Information about your child's dental health or previous treatment_____

_____

Do you presently have any concerns with any of the following regarding your child? Please ☑ Yes or ☑ No

☐Y ☐N Appearance
☐Y ☐N Bad breath
☐Y ☐N Broken teeth
☐Y ☐N Jaw pain or grinding
☐Y ☐N Lost fillings
☐Y ☐N Pain or discomfort
☐Y ☐N Sensitivity (hot/cold/pressure/sweets)
☐Y ☐N Sore or bleeding gums
☐Y ☐N Speech problems

Has your child ever had any of the following? Please check ☑Yes or ☑No

☐Y ☐N Adverse reaction
☐Y ☐N Root Canal Treatment
☐Y ☐N Orthodontic treatment
☐Y ☐N Gum treatments or surgery
☐Y ☐N Extractions
☐Y ☐N Mouth or chin injury
☐Y ☐N Speech Problems

Office Use _____

MEDICAL INFORMATION

Physician's Name _____ Phone _____ When was your child's last check up? _____

Is your child currently undergoing medical treatment ☐Y ☐N? If so, please explain _____

Has your child ever taken Fen-Phen/redux? ☐Y ☐N Has your child ever had a blood transfusion? ☐Y ☐N

Has your child ever had, please check ☑ Yes or ☑No

☐Y ☐N AIDS/HIV positive
☐Y ☐N Anemia
☐Y ☐N Anxiety
☐Y ☐N Asthma
☐Y ☐N Atopic (allergy prone)
☐Y ☐N Blood Disease
☐Y ☐N Cancer
☐Y ☐N Chicken Pox
☐Y ☐N Convulsions/Epilepsy
☐Y ☐N Cough, persistent
☐Y ☐N Cough up blood
☐Y ☐N Diabetes
☐Y ☐N Epilepsy
☐Y ☐N Fainting
☐Y ☐N Food Allergies
☐Y ☐N Headaches
☐Y ☐N Hearing Impairment
☐Y ☐N Heart Problems
☐Y ☐N Hemophilia/Abnormal Bleeding
☐Y ☐N Kidney Disease or Malfunction
☐Y ☐N Liver Disease
☐Y ☐N Material Allergies (latex/wool/metal)
☐Y ☐N Respiratory Disease
☐Y ☐N Shortness of breath
☐Y ☐N Sinus Problems
☐Y ☐N Skin Rash
☐Y ☐N Thyroid disease
☐Y ☐N Tonsillitis
☐Y ☐N Tuberculosis
☐Y ☐N Other: _____
_____
_____

Medications: _____ List allergies, if any: _____

_____ _____

Office Use _____

AUTHORIZATION

☐ BY CHECKING THIS BOX, I CONFIRM THAT I HAVE REVIEWED THE INFORMATION ON THIS QUESTIONNAIRE, AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE. IF THERE IS ANY CHANGE IN MY MEDICAL STATUS, I WILL INFORM THE DENTIST. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES RELATED TO SERVICES PROVIDED AND PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE.

GUARDIAN AUTHORIZATION _____ DATE _____

DENTIST'S AUTHORIZATION _____ DATE _____