Dr. Molly Rodgers

Pediatric Patient Information Form

Patient's Name

Date of Birth

Nickname

Weight

Height

Address

Postal Code

School

Grade

Physician

Physician's Phone Number

Physician's Address

Is your child covered by an insurance plan?

Social Assistance# (if applicable)

Father's Full Name

Father's Occupation

Father's Business Phone Number

Mother's Full Name

Mother's Occupation

Mother's Business Phone Number

Or Legal Guardian's Full Name

Legal Guardian's Occupation

Legal Guardian's Phone Number

Are you aware of your child having any particular dental problems?

- Yes
- No

If so, what?

Is your child having any dental discomfort or pain?

- Yes
- No

Is this your child's first visit to a dental office?

- Yes
- No

If not, when was the last dental examination?

Who was your child's last dentist?

Has your child had any bad dental experiences?

- Yes
- No

Is your child allergic to any food or drugs?

- Yes
- No

If so, what?

Has your child ever been hospitalized?

- ○ Yes
- ○ No

If so, for what reason?

Is your child suffering from a serious illness or disease at the present time?

- ○ Yes
- ○ No

If so, for what reason?

Is your child taking drugs or medications at the present time?

- ○ Yes
- ○ No

If so, for what?

For what reason?

Has your child ever had:

- ☐ Heart trouble
- ☐ Lung trouble
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Kidney trouble
- ☐ Liver trouble
- ☐ Blood disorders
- ☐ Anemia
- ☐ Jaw injury
- ☐ Diabetes
- ☐ Thyroid trouble
- ☐ Pneumonia
- ☐ Asthma
- ☐ Cancer

If Cancer, what kind?

Others

This is to certify that I, undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anesthesia and any necessary sedation as indicated. I agree to make payment for services upon completion at each appointment, by cash, cheque or credit card unless other arrangements have been previously and specifically made with the dentist.

I also understand that there will be a charge for appointments missed without sufficient notice.

Parent (or Guardian's) Signature

Date

Insurance Information

Name of Insured:

Insured Date of Birth

Place of Employment:

Insurance Carrier:

Group/Policy#:

Cert/ID#:

Secondary Insurance

Name of Insured:

Insured Date of Birth

Place of Employment:

Insurance Carrier:

Group/Policy#:

Cert/ID#:

Photo/Release Form

Adult Release:

☐ I, the undersigned, herby give permission of images of myself, captured during regular activities of the Dr. Molly Rodgers Dental office, through video, still photo, digital imaging or any other such means, to be used for the purpose of advertising, promotion on the company website and any social media deemed applicable. I consent to such uses and hereby weave all rights to compensation.

Child Release:

☐ I, the undersigned, am the parent/guardian of the minor child named below and hereby give permission of images of my child, captured during regular activities of the Dr. Molly Rodgers Dental office, through video, still photo, digital imaging or any other such means, to be used for the purpose of advertising, promotion on the company website and social media. I consent to such uses and hereby waive all right to compensation.

Name of Child:

Name of Adult or Parent/Guardian:

Today's Date: