Dr. S. J. Weinberger
PEDIATRIC DENTISTRY & ORTHODONTICS
1179278 Ontario Ltd.

577 Oxford Street East, London, ON N5Y 3H9
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MEDICAL-DENTAL HISTORY FORM:
FOR CHILDREN / TEENS

A

Child's Name: (Last) _____ (First) _____

Prefers to be Called: _____ F ☐ M ☐ Age: _____ Birthdate: _____ d / m / y

Mailing Address: _____ Email Address: _____

City: _____ Postal Code: _____ Home Phone # _____

Mother / Guardian: (Last) _____ (First) _____ Work # _____

Father / Guardian: (Last) _____ (First) _____ Work # _____

Parent is ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Common Law

Names and Ages of Brothers and Sisters: _____

Emergency Phone # and Name where we can leave a message: _____

Referred by: _____

Name of Person Responsible for Account: _____

B - DENTAL BENEFITS

☐ No Dental Coverage

☐ Insurance Benefits through an Employer

Name of Insured: _____ Birthdate: _____ d / m / y

Place of Employment: _____

Name of Insurance Company: _____

Policy / Group # _____ ID / Certificate # _____

☐ Secondary Benefits through a Spouse's Employer

Name of Insured: _____ Birthdate: _____ d / m / y

Place of Employment: _____

Name of Insurance Company: _____

Policy / Group # _____ ID / Certificate # _____

C - GOVERNMENT COVERAGE

NOTE: ANYONE COVERED BY A GOVERNMENT DENTAL BENEFIT PLAN MUST HAVE PROOF OF COVERAGE FOR THE CURRENT MONTH AT EACH APPOINTMENT.

☐ Ontario Works ☐ ODSP

Cardholder's Name: _____ Birthdate: _____ City: _____

☐ CINOT ☐ CAS ☐ HSOS ☐ Other: _____

D

Please indicate your choice of payment option: ☐ Cash / Debit Card ☐ Visa ☐ Mastercard

I have read and understand the office policy of Pediatric Dentistry: ☐ Yes ☐ No

Date: _____ Signature of Parent or Guardian: _____