Holland Bloorview
Kids Rehabilitation Hospital

DENTAL SERVICES

PATIENT INFORMATION

Chart # _____

Name: _____ (Last) _____ (First) ☐ Male ☐ Female

Date-of-Birth: _____ (Year) _____ (Month) _____ (Day)

_____ (Health Card Number) _____ (Version Code)

Health Card Expiry Date: _____ (Year) _____ (Month) _____ (Day)

Medical Diagnosis (list): _____

Physician Name: _____ Telephone #: _____

Dentist Name: _____ Telephone #: _____

Referred by: _____ Telephone #: _____

Reason for Referral: _____

_____ (Address) _____ (Apt. #) _____ (City) _____ (Province) _____ (Postal Code)

Telephone Numbers: _____ (Home) _____ (Cell) _____ (Work) _____ (Ext. #)

PARENT / GUARDIAN INFORMATION

(Please complete if patient under 18 or unable to complete on own)

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

Email Address: _____

Telephone # (Home): _____

Telephone # (Work): _____

Telephone # (Cell): _____

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

Email Address: _____

Telephone # (Home): _____

Telephone # (Work): _____

Telephone # (Cell): _____

I consent to Holland Bloorview dental services sending emails. I reserve the right to have my email removed.___(initial)

Guardian Name: _____ Telephone #: _____

Group Home Name: _____ Telephone #: _____

Pharmacy Telephone#: _____

The personal information you give us on this form helps us provide you with services at Holland Bloorview. We collect, use and share this information under the authority of the Public Hospitals Act. If you have questions, please contact the privacy office at 416-425-6220 ext. 3467 or privacy@hollandbloorview.ca.

Parent/Guardian/ Patient (18yrs+) _____ (Print Name) _____ (Signature) Date _____