NEW PATIENT FORM

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information is strictly confidential. A member of our team will be able to assist you with the completion of this form. PLEASE PRINT.

PATIENT NAME (SURNAME, GIVEN): ____________________

PREFERRED NAME: ____________________

BIRTH DATE (MM/DD/YY): ____________________ AGE: ________ SEX/GENDER: ________

MANITOBA HEALTH PHIN #: ____________________

SIX DIGIT REGISTRATION #: ____________________

MAILING ADDRESS (N°, STREET, CITY, PROVINCE, POSTAL CODE): ____________________

____

____

HOME PHONE: ____________________ OTHER PHONE: ____________________

CONTACT EMAIL: ____________________

REASON FOR TODAYS VISIT: ____________________

May we leave a voicemail regarding your appointment at these numbers? Yes ☐ No ☐

We would like to send you email and text communications which may include appointment confirmations, newsletters, upcoming events, and important notifications. Check the box if you would like to receive future email and text communications from us. Yes ☐ No ☐

HOW DID YOU HEAR ABOUT US?

Referred from an existing patient or staff member (family, friend or colleague), internet, community, professional referral (another health care professional), emergency/walk-in or other:

____

Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require **24 hours' notice**, otherwise it may be necessary to charge for the time lost.

____________________ ____________________

Signature PARENT ☐ GUARDIAN ☐ CAREGIVER ☐ Date

FAMILY PHYSICIAN: ____________________ **PHONE:** ____________________

IN CASE OF EMERGENCY NOTIFY: ____________________

RELATION: ____________________ PHONE: ____________________

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PARENT/GUARDIAN/CAREGIVER 1 INFORMATION

NAME (SURNAME, GIVEN):____

RELATION: ____________________

IS THE PARENT/GUARDIAN'S ADDRESS THE SAME AS THE CHILD'S ADDRESS? Y ☐ N ☐ N/A ☐

ADDRESS (N°, STREET, CITY, PROVINCE, POSTAL CODE): ______________________________

____

PHONE:_________________________

OCCUPATION: _________________________ WORK PHONE: ___________________________

PARENT/GUARDIAN/CAREGIVER 2 INFORMATION (IF DIFFERENT THAN ABOVE)

NAME (SURNAME, GIVEN): ____

RELATION: ____________________

ADDRESS (N°, STREET, CITY, PROVINCE, POSTAL CODE): ______________________________

____

PHONE:_________________________

OCCUPATION: _________________________ WORK PHONE: ___________________________

PLEASE LIST ANY OTHER PERSONS WHO MAY HAVE ACCESS TO THIS FILE (E.G. SCHEDULING APPOINTMENTS)

NAME: ___________________________________ RELATION: ___________________________

INSURANCE INFORMATION (IF THE PATIENT HAS A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING)

SUBSCRIBER:________________________________ D.O.B(MM/DD/YY): ____________________

RELATION: ____

INSURANCE CO: ____

POLICY PLAN#: ____

DIVISION/SECT.#: ______________________ SUBSCRIBER ID: ___________________________

SUBSCRIBER:________________________________ D.O.B(MM/DD/YY): ____________________

RELATION: ____

INSURANCE CO: ____

POLICY PLAN#: ____

DIVISION/SECT.#: ______________________ SUBSCRIBER ID: ___________________________

WHO IS FINANCIALLY RESPONSIBLE FOR THIS CHILD:

Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Both ☐ Other ☐____________________

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PATIENT DENTAL HISTORY

1. Does the patient need to take antibiotics before dental work? .... Y ☐ N ☐
   If yes, please explain:
   ____

2. Please list any other information that you feel we should have to provide you with the best possible dental care:
   ____
   ____

3. Last Dental Visit ______________________ Cleaning ____________________ X-Rays ______________

4. Does the patient have any allergies? .... Y ☐ N ☐
   If yes, please list using the categories below:

   Medications:____

   Latex/Rubber Products: ____

   Other (e.g. hay fever, foods, etc.): ____

HABITS/HYGIENE

Please check all that apply

☐Thumb/Fingers/Object Sucking ☐Mouth Breathing ☐Lip Biting ☐ Pen Biting

☐Nail Biting ☐Chewing Gum ☐Tongue Thrust ☐Flossing

☐Tooth clenching/grinding

MEDICAL HISTORY

Please indicate if the patient has any of the following conditions

☐Diabetes ☐Blood Disorders (hemophilia, anemia, prolonged bleeding) ☐Heart Disease ☐Epilepsy

☐Heart Problems ☐Hay Fever/Seasonal Allergies ☐Heart Murmur ☐Frequent colds

☐Sickle Cell ☐Liver Disorders ☐Asthma ☐Convulsions/Seizures

☐Mental Disorder ☐Ear Diseases ☐Blood pressure (High or Low) ☐HIV/AIDS

☐Frequent Headaches ☐Cancer ☐Tuberculosis ☐Other: ______________

Please provide details on any conditions selected above.

____

Thank you for completing this personal history of your child. The information that you supplied allows us to more adequately plan for your child's emotional and dental needs while making a thorough evaluation of your child's dental health. I, the undersigned, hereby declare the above statements are to the best of my knowledge, true, and correct. Furthermore, I authorize ordinary dental diagnostic procedures, including radiographs and photographs, to determine the dental needs of my child.

____ ________________________________

(Signature) ☐Parent ☐Guardian ☐Caregiver DATE

____ ________________________________

(Reviewed by Dentist): DATE

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DENTISTRY FOR CHILDREN

Financial Policy Agreement

Thank you for choosing Toddlers to Teens for your dental needs! We are committed to providing you with excellent care and convenient financial arrangements. We encourage you to be an active and informed participant in your child's care. Accordingly, financial arrangements are the result of open and honest discussions of diagnoses and recommended treatment options. To confirm your understanding and agreement with our policies, please read the following.

Payments:
Payment in full is due at the time services are rendered unless insurance information is provided. Any difference not covered by insurance will be required at the time of services. We accept Visa, Mastercard, Debit and Cash.
Personal cheques are not accepted.

Estimates:
We will do our best to provide you with an estimate for the cost of any dental procedure. These are estimates because it is often impossible to know exactly how much a specific treatment will cost until after it is done. For example, a cavity may appear small on a radiograph but when the decay is removed, it is possible that the required filling is larger than originally anticipated. Similarly, it may appear that a tooth needs a root canal, but if the dentist observes a fracture during the procedure, he or she might need to change the treatment plan.

Insurance:
Our office is committed to helping patients get the most benefit from their dental insurance; however, insurance policies vary greatly. Therefore, due to the complexity for Insurance contracts, you are fully responsible for knowing your own insurance plan and what treatment it does and doesn't cover. Treatment is recommended based on what you need NOT on insurance coverage. As a courtesy, we will gladly send your claim electronically for you, on your behalf, to your insurance company providing that your company does allow electronic submission.

Minors:
A parent or guardian must accompany all minors to their dental appointments. The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment unless otherwise provided.

Missed Appointments:
Once an appointment has been made, a room is reserved specifically for you and the dentist/dental hygienist's time is set aside. Please be considerate of other patients and our clinic and allow at least **one business day** to change or cancel an appointment in order to avoid a service fee. Service fees will be applied to patients who miss appointments without notice at a rate of **$40.00.**

Financial Consent and Authorization for Treatment:
We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family. Regardless of any insurance coverage, your insurance policy is a contract between you and your insurance company. We cannot guarantee payment or coverage of your claim.

I agree to pay all fees and charges for services rendered at Toddlers to Teens. I agree to pay all charges when presented with a statement unless prior credit arrangements are agreed upon in writing. I understand and agree, regardless of my insurance, that I am ultimately responsible for any unpaid balance on my account.

Patient Name: ____

Parent/Guardian Name: ____

Signature of Parent / Guardian: ______________________________________

Electronic Communication

☐ I agree to receive email and/or text messages from Toddlers to Teens which may include appointment confirmations, newsletters, upcoming events and important notifications.

*You can withdraw your consent at any time.