KOOTENAY LIFE DENTAL

PATIENT INFORMATION

Date: _____

Child's Name: (last)_____(first)_____(preferred)_____
Address:_____
City: _____ **Province/State**:_____ **Postal/Zip Code**:_____
Birthdate (mm/dd/yr): _____ **Health Care Number**: _____ **Gender**:Male ☐ Female ☐
Who is accompanying the child today? Name: _____
Relation: Biological ☐ Adopted ☐ Foster ☐ Other: _____
Are you covered by a dental insurance plan? Yes ☐ No ☐

PARENT/GUARDIAN INFORMATION

Father ☐ **Stepfather** ☐ **Guardian** ☐
Name: (last)_____(first)_____(preferred)_____
Address: _____
City:_____ **Province/State**:_____ **Postal/Zip Code**:_____
Employer:_____ **Phone Number**: (home)_____(cell)_____(work)_____
Marital Status: Married ☐ Separated ☐ Divorced ☐ Single ☐ Widow ☐ Common law ☐ Other:_____
Birthdate (mm/dd/yr) :_____ **Email:**_____

Mother ☐ **Stepmother** ☐ **Guardian** ☐
Name: (last)_____(first)_____(preferred)_____
Address: _____
City:_____ **Province/State**:_____ **Postal/Zip Code**:_____
Employer:_____ **Phone Number**: (home)_____(cell)_____(work)_____
Marital Status: Married ☐ Separated ☐ Divorced ☐ Single ☐ Widow ☐ Common law ☐ Other:_____
Birthdate (mm/dd/yr):_____ **Email:**_____
Person responsible for account? _____ **Patient resides with**?:_____

MEDICAL AND DENTAL HISTORY

	Yes	No
Is your child currently under the care of a physician?	☐	☐
Physician name:_____		
Clinic:_____		
Has your child been hospitalized in the last 5 years?	☐	☐
Reason:_____		
Are your child's immunizations up to date?	☐	☐
Is this your child's first time to the dentist?	☐	☐
Has your child had previous dental treatment?	☐	☐
If so, how did it go?_____		

	Yes	No
Does someone assist child when brushing or flossing?	☐	☐
How often does child brush?_____		
How often does child floss? _____		
Does your child go to bed with a bottle or sippy cup?	☐	☐
If yes, what is inside?_____		
Does your child receive fluoride?	☐	☐
If yes, how?_____		
How was your child fed as an infant? Bottle ☐ Breast ☐		
Is your child currently taking any medications?	☐	☐
Please list:_____		

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HEALTH HISTORY

Please mark (X) your responses:

	Yes	No
Asthma	☐	☐
Autism	☐	☐
Bleeding Problems	☐	☐
Cancer- Type:_____ When:_____	☐	☐
Chicken Pox	☐	☐
Cleft Lip/Palate	☐	☐
Developmental Delay	☐	☐
Diabetes-Type:_____	☐	☐
Epilepsy	☐	☐
Hearing Problems	☐	☐
Heart Disease	☐	☐
Heart Murmur	☐	☐
Learning Disability	☐	☐
Mentally Challenged	☐	☐
Premature Birth	☐	☐
Psychiatric Care	☐	☐
Rheumatic Fever	☐	☐
Skin Rash/Eczema/Psoriasis	☐	☐
Thyroid Disease	☐	☐
Vision Problems	☐	☐
Other:_____ _____		

ALLERGIES

Local Anesthetic ☐ Penicillin ☐ Latex ☐ Seasonal ☐

Any other allergies to medication?:_____

Any food allergies?:_____

Other?_____

	Yes	No
Is there anything that the dentist should know regarding your child's medical history that has not been mentioned?	☐	☐

OFFICE POLICY PRIVACY AND CONSENT FOR SERVICES

All professional services must be paid for by cash, or acceptable credit/debit card at the time each service is performed. No exception. An estimate of treatment costs will be given to all patients with a treatment plan. This is ONLY AN ESTIMATE. Final costs for services may be higher or lower.

Patients with dental insurance understand that all dental services are charged directly to your insurance and you are responsible for the balance at the time of service.

It is YOUR benefit plan, therefore it is your responsibility to: Understand that some procedure codes may not be eligible under your benefit plan contract, fully understand and review your pre-determination, check annual maximum and deductible and expiry date of the pre-determination, provide our office with your pre-determination if more information is required and inform our office of any changes to your dental plan and / or employment, be aware that your benefits may be affected if you are entitled to benefits under any other plan.

If you wish to cancel an appointment you must give a minimum of 24 hour notice, otherwise you will be charged professional time lost. I authorize the communication of information related to treatment and to the coverage of services described in all forms to my general dentist. I also authorize release of information contained in my claim forms to my insured company/ plan administrator.

I have read the above conditions of treatment and payment and agree to their content

Signature: _____ **Date:** _____ **Relationship to Patient:** _____

Signature of parent or guardian (mm/dd/yr)