KIDS DENTAL INFORMATION

PATIENT'S NAME _____
Last First Initial

D.O.B.: _____ Gender (M/F):_____ MB Health #: _____PHIN:_____
DD / MM / YY

Address:_____
Street City

_____
Province Postal Code

Contact Phone numbers:

Parent's/Guardian's Name: _____Home number:_____

Employed by:_____Work #_____ext:_____Cell # _____

Parent's/Guardian's Name: _____Home number:_____

Employed by:_____Work #_____ext:_____Cell # _____

Please indicate which phone number is your prefered contact: _____

E-mail: _____

Who may we thank for this referral?_____

REGISTRATION

KIDS DENTAL

128-2025 Corydon Avenue
Winnipeg, MB R3P 0N5
204-222-5437
www.kidsdental.ca

Method of Payment

- ❑ Cheque
- ❑ Credit Card
- ❑ Debit
- ❑ Cash

Kids Dental Billing Policy

Kids Dental is a specialty office with all fees collected after every appointment.

We accept cash, interac, cheques and all major credit cards.

We do not accept assignment from dental insurance. However we are pleased to process your dental claims to your insurance carrier of choice for direct reimbursement.

Other Family Members in this Practice: _____

DENTAL INSURANCE 1st COVERAGE

Insured Name: _____

Date of Birth: _____
DD / MM / YY

Employer: _____

Insurance Co.: _____

Group or Policy: _____

ID or Certificate #: _____

DENTAL INSURANCE 2nd COVERAGE

Insured Name: _____

Date of Birth: _____
DD / MM / YY

Employer: _____

Insurance Co.: _____

Group or Policy: _____

ID or Certificate #: _____

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist or medical professional.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.

I understand that by providing my email address I may be emailed periodically by Kids Dental (or our related sister clinics) regarding promotions, newsletters and various marketing initiatives, and may unsubscribe at any time.

I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature:_____ Date:_____

BILLING INFORMATION

KIDS DENTAL

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____/_____/_____
DD MM YY

DENTAL HISTORY

Is this your child's first visit to the dentist? YES NO

If no: Previous Dentist: _____

Date of last visit: _____

Were any x-rays taken? YES NO

Have there been any injuries to your child's teeth (e.g. falls, chips, etc)? YES NO

If yes, describe: _____

MEDICAL HISTORY

Name of paediatrician or family physician: _____

Is your child currently taking any medications or drugs? YES NO

If yes, state why and list: _____

Has your child ever had a bad reaction to drugs, including antibiotics or local /general anaesthetics? YES NO

If yes, explain: _____

Has anyone in your family had a bad reaction to drugs, including antibiotics or local/general anaesthetics? YES NO

If yes, explain: _____

Has your child ever had surgery or been hospitalized? YES NO

If yes, explain: _____

Has your child ever been diagnosed with any of the following conditions (please circle):

ADD/ADHD	Autism	Eye Problems	Rheumatic Fever
Allergies	Bleeding Disorder	Hearing Loss	Seizures
Drug	Cancer	Heart Disease	Sickle Cell Anaemia
Environmental	Cerebral Palsy	Hepatitis	Speech Problems
Food	Cleft Lip/Palate	HIV/AIDS	Syndrome:
Latex	Developmental Delays	Kidney Disease	_____
Anaemia	Diabetes	Liver Disease	Other:
Asthma	Epilepsy	Mentally Challenged	_____

Details: _____

_____

Is there anything else we should know about your child's health or medical condition? YES NO

If yes, explain: _____

I acknowledge that the above information is complete and accurate.

Parent / Guardian Signature: _____ Date: _____

CHILD MEDICAL AND DENTAL HISTORY