FIELDSTONE DENTAL LTD

New Patient - Child

We are committed to providing the most comprehensive care possible and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better care we can give you. If you have any questions or need assistance, please ask – we would be happy to help!

ABOUT YOU

Last Name_____ First Name_____ Middle Name_____

Date of Birth _____/_____/_____ (Month / Day / Year)

Guardian 1_____Relationship_____

Guardian 2_____ Relationship_____

Home Phone #_____ Work #_____ Cell # _____

Mailing Address: _____ City_____

Province: _____ Postal Code: _____

Email Address: _____

Preferred Method of Contact: Call _____ Text _____ Email_____

Appointment Reminder – Do you prefer a phone call or text message? PLEASE CIRCLE

INSURANCE INFORMATION

Name of Policy Holder: _____

Date of Birth (Policy Holder): _____

Name of Insurance Company: _____

Subscriber Group/Plan #: _____Subscriber ID/Certificate #: _____

Place of Employment: _____

Relationship to Policy Holder: Self _____ Dependent_____

Are you claiming through more than one insurance? YES _____ NO_____

If so, please complete the next section.

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: _____

Date of Birth (Policy Holder): _____

Name of Insurance Company: _____

Subscriber Group/Plan #: _____Subscriber ID/Certificate #: _____

Place of Employment: _____

DENTAL HISTORY

Reason for today's visit: Check-Up _____Cleaning _____Toothache _____ Other _____

Date of last visit? _____Previous Dentist: _____

What was done? _____

Who may we thank for referring you? Internet _____Mail/Advertisement _____Friend/Family_____

MEDICAL HISTORY

Family Physician: _____Phone #: _____

Are there any other medical problems we should be aware of? _____

_____

Is your child currently undergoing treatment from their Medical Doctor?	YES	NO
Does your child have any congenital heart conditions?	YES	NO
Does your child have any allergies? (Penicillin, Aspirin, Codeine or Latex)	YES	NO
Does your child take any medications, prescription or otherwise?	YES	NO
List of medications: _____		
Does your child have difficulty chewing?	YES	NO
Has your child had orthodontic treatment?	YES	NO
Have siblings or parents had orthodontic treatment?	YES	NO

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I authorize the dentist to preform procedures and consent to treatment and I will assume responsibility for the fees associated with those procedures/treatment. I authorize the release of my personal information regarding my diagnosis or treatment to my insurance company or any other dental profession.

APPOINTMENT POLICY

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. Our office policy states that patients must give us 1 business day (24 hours) notice if they cannot keep an appointment. Appointment changes with less than 48-hour notice are subject to a service fee of $100.00. It is my responsibility to confirm appointments and understand that if I do not confirm my appointment, there is a risk of the appointment being rescheduled. Patients that do not show up for appointments may not be booked again.

FINANCIAL POLICY, AUTHORIZATION & CONSENT

All patients are required to pay for treatment the same day at the end of appointment.

Should you have insurance, our office will direct bill your insurance company, leaving the estimated patient portion to be paid at the end of your treatment. The patient will be responsible for all costs that the dental insurance plan does not cover. If you would like to know more about your insurance plan (s) and what they cover, please ask and we can help you find out.

-We do accept cash, debit, Visa and Mastercard. Dental insurance plans often pay less than the actual fee for the service.

-I agree and consent to a dental examination and treatment. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to completion.

-I authorize Fieldstone Dental to bill my insurance company and understand and comply with all policies.

Signature: _____ **Date:** _____