



## 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 perform procedures and consent to treatment and I will assume responsibility for the fees associated with that 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 2 business day (48 hours) notice if they cannot keep an appointment. Appointment changes with less than 2 business days (48 hours) 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 parent/guardian 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 **parent/guardian** portion to be paid at the end of your treatment. **The parent/guardian 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 submit a pre-determination. It is ultimately the parent/guardian responsibility to know and understand their insurance benefits.

We do accept cash, debit, Visa, Mastercard and e-transfer. Dental insurance plans often do not pay the full current Manitoba fee guide and patients are responsible for the difference at the end of each appointment.

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.

**AI Policy**

This practice may use AI tools to assist in documentation and communication. No diagnostic decisions will be made by AI. All care is supervised and reviewed by a licensed clinician.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_