

# 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:

Mother's name: \_\_\_\_\_ Home number: \_\_\_\_\_

Employed by: \_\_\_\_\_ Work # \_\_\_\_\_ ext: \_\_\_\_\_ Cell # \_\_\_\_\_

Father's name: \_\_\_\_\_ Home number: \_\_\_\_\_

Employed by: \_\_\_\_\_ Work # \_\_\_\_\_ ext: \_\_\_\_\_ Cell # \_\_\_\_\_

Please indicate which phone number is your preferred contact: \_\_\_\_\_

## Legal Custody *Please provide documentation as necessary*

Joint\*  Mother  Father  Guardian  Agency  Other

\*Joint Custody is when those parents have a legal custody agreement in place for the child

E-mail: \_\_\_\_\_

Who may we thank for this referral? \_\_\_\_\_



Tuxedo Park Shopping Centre  
128-2025 Corydon Avenue  
Winnipeg, MB R3P 0N5  
204-222-KIDS (5437)

# 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 1<sup>st</sup> COVERAGE

Insured Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
DD / MM / YY

Employer: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Group or Policy: \_\_\_\_\_

ID or Certificate #: \_\_\_\_\_

### DENTAL INSURANCE 2<sup>nd</sup> 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 attest to the accuracy of the information on this page.

By checking this box I agree to receive periodic emails by Kids Dental (or our related sister clinics) regarding promotions, newsletters and various marketing initiatives, and may unsubscribe at any time.

Patient's or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## BILLING INFORMATION



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: \_\_\_\_\_