Happy Teeth
PEDIATRIC DENTISTRY

Find us at: 16 - 3105 31st St. Vernon, BC
Contact us at: vernonkidsdentist@gmail.com | 250-542-5451

Child's Full Name: _____ Preferred Name:_____

Age: _____ Date of Birth: _____ Gender: (F)____ (M)____ (O)____

Home Address: _____

City/Town: _____ Postal Code: _____

Best Contact Phone #: _____-_____-_____

Care Card #/ PHN: _____-_____-_____ Insurance: **YES / NO**

Child's Physician: _____

Parent 1/ Legal Guardian (full name): _____

*Address (if different from above): _____

Phone #: _____-_____-_____ Relationship to Child: _____

Email: _____

- -

Parent 2/ Legal Guardian (full name): _____

*Address (if different from above): _____

Phone #: _____-_____-_____ Relationship to Child: _____

Email: _____

Dental Insurance Company (1st Carrier): _____

Insured Name: _____ Date of Birth: _____

Policy/ Group #: _____ Employer ID#/ Subscriber ID#: _____

- -

Dental Insurance Company (2nd Carrier): _____

Insured Name: _____ Date of Birth: _____

Policy/ Group #: _____ Employer ID#/ Subscriber ID#: _____

Additional Insurance:

Is your child covered under any other benefit plans? (Healthy Kids, Indian affairs, etc.) **YES / NO**

If yes, what is the child' s identification/ registration/ status #? _____

Name of Child's Siblings: _____

Pediatric Dental & Medical History:

These questions are of great value in helping me to better understand your child.
All information provided will remain CONFIDENTIAL.

Dental History:

What is the reason for this visit? _____

When did your child last receive dental treatment? _____

Have dental x-rays been taken for your child? **YES / NO** If **YES**, when (approx.)? _____

Do YOU have any concerns about your child's mouth/teeth? _____

Has your child had any unfavorable experiences in a dental/ medical office? **YES / NO**
Please describe: _____

How would you describe your child's temperament? _____

Does your child have any of the following habits that might affect his/her teeth or mouth...

Does your child brush his/her own teeth? **YES / NO** - How often in a day? _____
Does your child floss? **YES / NO**
Does your child use toothpaste? **YES / NO** - Does it contain Fluoride? **YES / NO**

Breaths through mouth? **YES / NO** Bites fingernails? **YES / NO**
Tongue habits? (sucking/ thrusting) **YES / NO** Grind teeth? **YES / NO**

Sucks thumb/ fingers? **YES / NO** - or - Age stopped: _____
Pacifier ? **YES / NO** - or - Age stopped: _____
Breastfed? **YES / NO** - or - Age stopped: _____
Bottle fed? **YES / NO** - or - Age stopped: _____

Medical History:

The following information is required to enable us to provide your child with the best possible care.
Please notify us of any medical changes, allergies, and/or new medications at any time in the future.

Is your child adopted or foster care? **YES / NO**

Were there any problems experienced during pregnancy? _____

Did your child have any problems during the 1st year of life? (medical/ dietary) _____

Has your child had a personal history of... (check box if YES)

Allergies - Drugs - Environment/ Dietary - Other _____	[ ] [ ] [ ]	Genitourinary Disorder - Bladder - Kidney - Other _____	[ ] [ ] [ ]
Heart Disease - Congenital - Rheumatic - Other _____	[ ] [ ] [ ]	Craniofacial - Cleft lip/ palate - Other _____	[ ] [ ]
Respiratory Disorder - Asthma - Cystic fibrosis - Other _____	[ ] [ ] [ ]	Endocrine Disorder - Diabetes type 1 - Diabetes type 2 - Other _____	[ ] [ ] [ ]
Gastrointestinal Disorder - Aspiration/ reflux - Feeding tube - Other _____	[ ] [ ] [ ]	Bleeding/ Blood Disorder - Hemophilia - Von Willibrands - Other _____	[ ] [ ] [ ]
Seizure Disorder		Cerebral Palsy	

Developmental Delay/ Learning Disorder		Liver Conditions	
Behavioral Problems		Malignant Hypothermia	
Autism/ Spectrum Disorder		Cancer	
ADHD		Immunodeficiency	
Emotional/ Anxiety Disorder		Transplant	
Skin Conditions		Premature Birth	
Limitations of arms or legs		OTHER: _____	

Does your child have or has had any medical conditions not listed above? **YES / NO**
If YES, please list:

_____

_____

Has your child ever been hospitalized or had a general anesthetic? **YES / NO**
If YES, please describe for what and when?

_____

_____

Is your child taking any prescription medications, over the counter medicines, or natural remedies?
YES / NO If YES, please list:

_____

_____

CONSENT TO TREATMENT:

It is necessary that a signed permission be obtained from a parent/ legal guardian before any and/ or all necessary dental services can be started, because your child is a minor. Authorization is hereby granted as such. If during the course of such treatment, in Dr. Coutu's opinion and judgment, any treatment or procedure different from that now contemplated should be indicated in respect of which there is no reasonable opportunity for additional explanation and authorization, you can further request and authorize her to do whatever she considers advisable. Furthermore, the individual indicated on this form will be responsible for any account incurred on this child for dental treatment and understand that the account is due at each appointment, or whatever arrangement has been previously mutually agreed upon with Dr. Coutu.

Date: _____

Name of Parent/ Legal Guardian (please print): _____

Signature of Parent/ Legal Guardian: _____

Financial Arrangements Approval Form:

Patient: _____

Dr. Coutu is a specialist in Pediatric Dentistry and follows the BC Dental Association's fee guide for specialists. The fees may be higher than those paid by your insurance plan.

Dental estimates are dependent on the cooperation of the patient, diagnostic radiographs and timely follow through of treatment. A delay of 6 months will require another exam to update the treatment plan. Estimates are honored for 45 days from the date of issue.

Dental insurance: Unlike most specialist offices, we do accept dental coverage. Please check your coverage for annual maximums and if they cover specialist fees. Predeterminations can usually go electronically to 1st carrier, 2nd carrier generally go by regular mail. Response from insurance companies may or may not be sent to our office. If you receive insurance details please share with us so that we can provide you with a more accurate estimate.

Deposits for hospital treatment that are used in full will be refunded once we have received payment from your insurance company.

In office appointments require 48 hour notice for cancellation. Short notice cancellations and missed appointments are subject to a $100.00 fee.

We accept cash (exact amount), and debit E-Transfers. Mastercard and Visa payments have a 3% charge.

My signature below certifies that I have read and agree to the policies outlined on this form and that I' am responsible for the fees associated with my child's treatment.

_____ _____

Signature Date