ToothZone Kids Dental Centre
Dr. Shylon Mathew & Dr. Natalie Mathew-Sanche
Certified Specialists in Pediatric Dentistry

225-1634 Harvey Ave.
Kelowna, BC V1Y 6G2
Phone: 778-484-5437

PATIENT INFORMATION

DATE: _____

Child's Legal Name: _____ Preferred Name: _____
Mailing Address: _____ City: _____
Province: _____ Postal Code: _____ Birth Date: ____/____/____ Age: _____ Gender: _____
MM DD YYYY
BC Care Card #: _____ Physician: _____
Who has Legal Custody: _____ Siblings and Ages: _____

FAMILY INFORMATION

☐ Mother ☐ Father ☐ Other: _____	☐ Mother ☐ Father ☐ Other: _____
Name: _____	Name: _____
Address if different from child: _____	Address if different from child: _____
Birth Date: ____/____/____ (MM DD YYYY)	Birth Date: ____/____/____ (MM DD YYYY)
Cell #: _____	Cell #: _____
Home #: _____	Home #: _____
Email: _____	Email: _____
Employer: _____	Employer: _____

INSURANCE INFORMATION

COVERAGE #1:	**COVERAGE #2:**
Insured Name: _____	Insured Name: _____
Policy Holder Birthdate: ____/____/____ (MM DD YYYY)	Policy Holder Birthdate: ____/____/____ (MM DD YYYY)
Insurance Company: _____	Insurance Company: _____
Group/Contract #: _____	Group/Contract #: _____
Certificate/Member ID #: _____	Certificate/Member ID #: _____
Relationship to Child: _____	Relationship to Child: _____

WHO MAY WE THANK FOR REFERRING YOU?

☐ Word of Mouth ☐ Street Sign ☐ Google/Website ☐ Magazine ☐ Sibling ☐ Social Media/Facebook
☐ Friend, if so who? _____ ☐ Referring Dentist: _____

What brings joy to your child? (pet, toy, game, friend, hobby, etc.) _____

MEDICAL HISTORY

Child Name: _____

Please check **YES** or **NO** for the following questions and add additional information as applicable

YES	NO	
		Is your child in good health?
		Has your child been hospitalized or had any past surgeries?
		If yes, please explain: _____
		Does your child have a history of allergies or sensitivities to anything?
		If yes, please describe: _____
		Is your child taking any medications?
		If yes, please list name and dose: _____

Has your child ever had/diagnosed with any of the following health problems?
Please check all that apply and describe below

☐ ADD/ADHD	☐ Congenital Birth Defects	☐ Endocrine/Growth	☐ Cerebral Palsy
☐ Asthma/Breathing/Lung	☐ Speech or Hearing	☐ Kidney/Liver Disease	☐ Cleft Lip/Palate
☐ Autism/ASD/PDD	☐ Eye/Vision	☐ Epilepsy	☐ Diabetes
☐ Behaviour/Learning	☐ Premature	☐ Anemia	☐ Down Syndrome
☐ Developmental Delays	☐ Fetal Alcohol	☐ Fainting/Dizziness	☐ Rheumatic or Scarlett Fever
☐ Blood Disease/Bleeding Disorder	☐ Seizure Disorder	☐ Bone/Muscle/Joint	☐ High/Low Blood Pressure
☐ Heart Disease	☐ Cancer/Tumors	☐ Endocrine/Growth	☐ Anxiety: General or Situational

☐ Other: _____

Additional Information: _____

_____

DENTAL HISTORY

What is the reason for your child's visit? _____

Please check **YES** or **NO** for the following questions and add additional information as applicable

YES	NO	
		Is this your child's first visit to the dentist? If no, date last seen: _____
		Has your child had dental x-rays before? If yes, date last taken: _____
		Does your child have a toothache or any other immediate dental problem?
		If yes, please explain: _____
		Has your child had any unfavorable dental experience?
		If yes, please explain: _____
		Has your child experienced any traumatic injuries to the face, teeth or mouth?
		If yes, please explain: _____
		Do you currently help your child brush? How often? _____
		Does your child floss? How often? _____
		Does your child use fluoridated toothpaste?

Please check if your child has any of the following habits?

☐ Thumb/Finger Sucking	☐ Pacifier	☐ Lip Sucking/Biting	☐ Mouthbreathing
☐ Nursing/Bottle	☐ Grinding	☐ Nail Biting	☐ Other: _____

Please check all traits that may apply to your child

☐ Friendly	☐ Strong Willed	☐ Quiet/Shy	☐ Whiney	☐ Withdrawn
☐ Approachable	☐ Independent	☐ Nervous/Fearful	☐ Stubborn	☐ Curious
☐ Talkative	☐ Reacts to Strangers	☐ Insecure	☐ Aggressive	☐ Active

Internal Use Only
Reviewed By: _____ & _____

PERSONAL INFORMATION PROTECTION ACT CONSENT

I hereby authorize ToothZone Kids Dental Centre to collect, disclose and use information provided by me to communicate with other health professionals, such as dentists and doctors, on my and my child's behalf. I authorize correspondence with my insurance provider to obtain dental coverage, estimates and process claims. Contact information will be used for communication regarding any treatment and/or hygiene appointments required, update patient files, send invoices and deliver reminders (by email, text, or phone), as needed.

Parent/Guardian Signature: _____

APPOINTMENT POLICY

Because we reserve your appointment time exclusively for you, we ask that you make every effort to keep your reserved appointment time. If you find that you cannot keep your scheduled visit, we require a minimum of 2 business days notice to reschedule/cancel. Advance notice allows us to see other patients who may have been waiting to see us for needed treatment. If sufficient notice is not provided, a charge of $50/patient will be applied to your account. Additionally, if more than one appointment is missed or cancelled without proper notice, you may be dismissed from the practice.

Parent/Guardian Signature: _____

FINANCIAL POLICY

Our fees are determined by the amount of time spent with the doctor, cost of materials, and lab fees. We base our fees on the British Columbia pediatric specialist fee guide. Payment is due in full the day of service. We accept cash, debit, or credit. Personal cheques will not be accepted. In instances where dental insurance is involved, there is no direct relationship between our office and your insurance company. Your coverage benefits are chosen by you and/or your employer and we have no control over the terms of your contract with them. As such, we also ask that these claims be paid in full on the day of service. ToothZone Kids will submit the dental claim to your insurance company so you may receive the reimbursement back as quickly as possible. ToothZone Kids accepts no responsibility for any uncovered amounts, benefit maximums, limitations or plan restrictions. Periodically we may accept assignment/insurance on your behalf at our discretion. In these cases, the amount that is not covered is due on the day of service. We recognize that unusual circumstances may incur a balance on the account. These balances must be paid within 30 days unless other arrangements have been made. If we have not received payment, further action may be taken by submitting your account to a collection agency.

Parent/Guardian Signature: _____

HEALTHY KIDS PROGRAM

Please be sure to provide your child's care card so that we may check to see if you qualify for the healthy kid's program which can cover a portion of our services (approx. 60%). This government funded plan is based on your income qualifications and if you are receiving MSP assistance. The balance that is not covered from the healthy kids program is your responsibility to pay on the day of service. Please inquire if you have any questions.

AUTHORIZATION

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to update the dental office of any changes in my child's medical status, contact and insurance information. I authorize the dental staff to perform routine dental services such as examinations, dental prophylaxis (cleaning), and x-rays (if needed to help diagnose and/or treat my child's dental condition). An informed consent/estimate will be given prior to any comprehensive dental treatment needed including fillings, crowns, extractions, dental appliances and nitrous oxide sedation. Photos and/or videos may be taken of my child for diagnostic or educational purposes.

Parent/Guardian Signature: _____

Child's Name: _____ **Date:** _____