Bedford South Dentistry
love your smile
15 Peakview Way Unit 300, Bedford South, NS, B3M 0G2
4-DENTAL(433-6825) www.bedfordsouthdentistry.com

New Patient Questionnaire – Children 5 and under

Patient's last name:	Patient's first name:

Gender:	Date of birth (DD/MM/YYYY):	**N.S. health card number: (REQUIRED!)**

MOTHER's last name:	MOTHER's first name:	Parent's date of birth (DD/MM/YYYY):
FATHER's last name:	FATHER's first name:	Parent's date of birth (DD/MM/YYYY):
GUARDIAN last name:	GUARDIAN first name:	GUARDIAN date of birth (DD/MM/YYYY):

CONTACT INFORMATION:

E-mail:	Main phone:	Secondary phone:
Full address:		

MEDICAL AND DENTAL INFORMATION:

Is this your child's first dental visit? (If no, indicate when his/her last visit was)	
How many times daily does your child have his/her teeth brushed?	
Does your child use a manual toothbrush or an electric toothbrush?	
Do you floss your child's teeth?	
Who primarily does the tooth brushing for your child?	
What type of toothpaste is your child using, if at all?	
Does the amount of toothpaste used resemble: a grain of rice, a pea, or a kidney bean?	
How many snacks does your child eat daily?	
How many meals does your child eat daily?	
Does your child use a sippy cup in between meals? What's in the cup?	
Does your child suck their thumb?	

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Does your child go to sleep with a bottle?	
Does your family drink city water, well water, or bottled water?	
Do you look inside your child's mouth to assess changes? If so, how often?	
Do you have any specific concerns or questions about your child's DENTAL health?	
Are there any known MEDICAL conditions?	
Is your child being treated by a medical doctor or specialist?	
Has your child ever been hospitalized?	
Does your child take any medications? Please list.	
Does your child have any allergies? (Please LIST ALL allergies – food, medicine, environmental)	

Please indicate why you chose our office

Friend recommendation/referral (please specify so that we may thank them)	
Family comes here	
Convenient location	
Internet (Google, Rate MDs, our website, Facebook, etc.) --- please specify	

Insurance Information

Dental insurance company name | policy | ID numbers: _____ | _____ | _____

(Provide secondary insurance plan information to receptionist)

Name/date of birth of plan member: _____

Patient's relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐

***IMPORTANT*: The Children's Oral Health Program, funded by Nova Scotia Medical Services Insurance (MSI) is a government subsidy that will cover a *portion* of children's dental care - 1 exam, 2 x-rays, and 15 min. of hygiene *once* every 365 days, plus *basic* restorative services. Claims *must be* sent to private insurance first before sending to MSI.**

NOTE: We require 48-hours' notice (two business days) to reschedule or cancel any appointment or we must apply an $80 charge to your account. This policy is essential for the efficient functioning of our dental office.

Parent signature and date: _____

Dentist signature and date: _____