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 NAME: Last_____ **First:**_____ **Middle Initial:**_____

PREFERRED NAME: _____ **PATIENT'S DOB (D/M/Y):** _____ **AGE:** _____

GENDER:_____ **PREF. PRONOUNS:** _____ **VALID HEALTH CARD #:**_____

PATIENT'S ADDRESS: _____

CITY: _____ **PROV:** _____ **POSTAL CODE:** _____

CONTACT #: C: _____ **H:**_____ **W:**_____

EMAIL:_____ **PREF. CONTACT METHOD:** _____

INSURANCE INFO: COMPANY:_____ **PLAN/GROUP #**_____ **CERT/ID#**_____

RELATIONSHIP TO INSURED: _____

PARENT, SPOUSE OR LEGAL GUARDIAN (If under the age of 18)

FULL NAME: _____ **RELATIONSHIP TO PATIENT:**_____

ADDRESS: ☐ SAME AS ABOVE _____

CONTACT #: C: _____ **H:**_____ **W:** _____

DOB (D/M/Y): _____ **EMAIL:** _____

INSURANCE INFO: COMPANY:_____ **PLAN/GROUP #**_____ **CERT/ID#** _____

FULL NAME: _____ **RELATIONSHIP TO PATIENT:**_____

ADDRESS: ☐ SAME AS ABOVE _____

CONTACT #: C: _____ **H:**_____ **W:** _____

DOB (D/M/Y): _____ **EMAIL:** _____

INSURANCE INFO: COMPANY:_____ **PLAN/GROUP #**_____ **CERT/ID#** _____

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?	

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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?	
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	

IMPORTANT*: The provincial 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 and 2 bitewing x-rays every 365 days, as well as 1-2 units (15-30 minutes) of scaling based on the age of the child and 2 fluoride treatments a year, plus *basic* restorative services. Parents are responsible for the cost of any additional services not eligible under the MSI program. I will provide valid credit card information at my first visit and authorization for use in the event that payment is needed for account balances for services not covered by insurance.

Be advised that claims *must always be* sent to private insurance first before sending to MSI (private insurance must be used up before we are permitted to submit claims to this government program for consideration).

NOTE: We require 48-hours' notice (two business days) to reschedule or cancel any appointment or we must apply an $102 charge to your account. This policy is essential for the efficient functioning of our dental office.

Parent/Guardian signature and date: _____

Dentist signature and date: _____