

1 Patient Details Please print clearly

Child's First Name:	How did you hear about us? Please check all that apply. <input type="checkbox"/> Website <input type="checkbox"/> Driving by location(s) <input type="checkbox"/> Live/work nearby <input type="checkbox"/> Online Search <input type="checkbox"/> Printed Advertisements <input type="checkbox"/> Other:	
Child's Last Name:		
Child's Preferred Name:		
Date of Birth:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:		
Relationship to Patient:		
Home Address:		
City:		
Province:		<input type="checkbox"/> I was referred by one of your patients: _____
Postal Code:		<input type="checkbox"/> Other family members seen by us: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
Parent/Guardian Home #:		
Parent/Guardian Work #:		
Parent/Guardian Mobile #:		
Parent/Guardian E-mail:		

2 Medical History Please print clearly

Name of Medical Doctor:	Doctor Telephone:
Has the child had any serious health problems within the past five (5) years? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes please give details:	Has the child had any surgeries within the past five (5) years? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes please give details:
Is the child currently taking any medications? Please list all medications below.	
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

2 Medical History (continued) Please print clearly

Have you been diagnosed with any of the following conditions? Please check all that apply.

<input type="checkbox"/> Asthma	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Mental/Nervous Disorders	<input type="checkbox"/> Kidney/Liver Disease
<input type="checkbox"/> Shortness of Breath/Chest Pain	<input type="checkbox"/> Back Problems/Surgery
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hemophilia/Blood Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Valve
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Heart Condition—please specify: _____
<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Cancer—please specify: _____
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Allergies—please specify: _____
<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Other—please specify: _____

3 Dental History Please print clearly

Is this the child's first visit to the dentist?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If no, please list date of last dental visit:
Does the child floss daily?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Does the child have any of the following habits:
Does the child brush daily?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do the child's gums ever bleed?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Does the child experience discomfort in his or her jaw?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Is there a family history of any of the following?
What are the child's favourite snack foods?		
What are the child's favourite drinks?		
		<input type="checkbox"/> Thumb Sucking <input type="checkbox"/> Chewing/Nail Biting <input type="checkbox"/> Mouth Breathing <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Dental Fear <input type="checkbox"/> Missing Teeth <input type="checkbox"/> Crooked Teeth <input type="checkbox"/> Spaced Teeth <input type="checkbox"/> High Decay Rate <input type="checkbox"/> Extra Teeth/Deformity <input type="checkbox"/> Other—please specify: _____

4 Insurance Please print clearly

List PRIMARY insurance information below:	List SECONDARY insurance information below:
Insurance Company:	Insurance Company:
Insurance plan/Group/Contract Number:	Insurance plan/Group/Contract Number:
Certificate/ID Number:	Certificate/ID Number:
Name of Insured:	Name of Insured:
Date of Birth of Insured: DD/MM/YYYY	Date of Birth of Insured: DD/MM/YYYY
Relationship to Patient:	Relationship to Patient:

5 Payment

We are a fee-for-service dental provider. Payment is due in full at the time dental treatment is rendered . We do not accept direct payment from insurance companies. If you have dental insurance, we will gladly submit your claim electronically, whereby you will be reimbursed directly by your insurance carrier, usually within three to five business days (for cheques), or within 48 hours (for direct deposit).

We accept cash, Visa, MasterCard and Interac payments for all goods and services.

6 Consent to Submit Dental Claims Electronically

I authorize release, to my benefits plan administrator and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to Dr. John Oueis and his associate dentists.

This authorization shall continue in effect until the undersigned revokes the same.

Signature of patient, parent or legal guardian:	Date: DD/MM/YYYY
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7 Authorization and Consent for Treatment

I certify that I have provided an accurate and complete personal and medical-dental history and I have not knowingly omitted any information.

I authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

I authorize the doctor to perform treatments and therapies that may be indicated (with my further consent) and I also consent to the use of local anesthetic agents.

I UNDERSTAND THE PREVIOUS STATEMENTS REGARDING PAYMENT OF FEES AND ACCEPT THE RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED FOR MYSELF AND/OR MY DEPENDENTS, DUE AND ARE PAYABLE WHEN SERVICES ARE RENDERED, UNLESS FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR.

- I authorize Dr. Singhal, Dr. Chopra and their associate dentists to release any information required to process my dental insurance claims.
- I understand that I am responsible for payment of the full balance on my account.

Signature of patient:	Date: DD/MM/YYYY
Signature of parent or responsible party:	Relationship to Patient:

8 Appointment Cancellation Policy

At Singhal Dentistry, appointments are made in advance by reserving the appropriate time slots to accommodate you and your treatment to be performed. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing and arranging set-up items prior to your arrival. This ensures that we achieve the high standard of care and treatment that we pride ourselves on.

Therefore, we kindly ask for **at least two (2) business days notice prior to any appointment changes or cancellations, so that we are able to waive the customary \$50 cancellation charge** a fee to offset some of the lost production and appointment preparation costs associated with your treatment. In addition, we can offer your appointment time to another patient. We appreciate your help in this matter.

Signature:	Date: DD/MM/YYYY
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