WHISTLER DENTAL
IN THE VILLAGE

WELCOME TO WHISTLER DENTAL - CHILD GUEST

LAST NAME	FIRST	MIDDLE	DATE OF BIRTH / / M / D / Y	SEX M ☐ F
HOME PHONE	CELL PHONE	WORK PHONE	PREFERRED CONTACT HOME ☐ WORK ☐ CELL ☐	
MAILING ADDRESS	CITY	PROV/STATE	POSTAL/ZIP CODE	
EMAIL ADDRESS			TODAY'S DATE	

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	HOME #	CELL #	WORK #

HOW DID YOU HEAR ABOUT OUR OFFICE? Referred by other person: _____
Other: _____

DOES YOUR CHILD HAVE DENTAL INSURANCE COVERAGE?

If yes, please provide the receptionist with your benefit information BC residents ONLY).
Primary Coverage YES ☐ NO ☐ Secondary Coverage YES ☐ NO ☐

Please answer the following questions to help us better care for your dental needs. All informations will be confidential and is for our records only.

GUARDIAN GENERAL INFORMATION

Full time Resident: _____ Seasonal Resident (living/working in Whistler for a period of time): _____
Part time Resident (between Whistler and another location): _____ Visitor/Tourist: _____ Working Visa: _____

DENTAL INFORMATION

Name of previous dentist: _____ Last dental visit: _____ Reason: _____
Your child routinely sees the dentist every: 3 mo. ☐ 4 mo. ☐ 6mo. ☐ 12 mo. ☐ Not Routinely ☐
IS YOUR CHILD CURRENTLY EXPERIENCING DENTAL PAIN? YES ☐ NO ☐ Explain: _____

WHAT IS YOUR CHILD'S IMMEDIATE CONCERN? _____

Are you interested in straightening your child's teeth? Y ☐ N ☐
When your child receives dental treatment would you consider yourself: Relaxed ☐ Mildly Apprehensive ☐
Nervous ☐ Extremely Nervous ☐

CHILDREN'S BITE, JAW, JOINT AND SLEEP HISTORY

Whistler Dental is proud to screen all children for proper craniofacial growth and delevopment.
Please check anything that applies to your child.

- ☐ Morning headaches
- ☐ Persistent runny nose
- ☐ Sucks thumb
- ☐ Uses soother
- ☐ Tonsils/Adeniods remain
- ☐ Daytime sleepiness
- ☐ Overweight
- ☐ Lips rest apart
- ☐ Teeth crowding
- ☐ Choking or gasping for air while sleeping
- ☐ Mood instability / aggressiveness / anxiety
- ☐ Difficulty waking up in the morning
- ☐ Mouth breather
- ☐ Soft diet
- ☐ Under weight
- ☐ Poor appetite
- ☐ Night terrors
- ☐ Bed wetting
- ☐ Falls asleep in bed or car
- ☐ Snores
- ☐ Grinds teeth
- ☐ Dark circles under eye Forward
- ☐ head posture
- ☐ Trouble paying attention in school
- ☐ CPAP user
- ☐ Premature birth
- ☐ Habit of biting objects
- ☐ Breast fed
- ☐ Bottle fed
- ☐ Other _____

CHILDREN'S MEDICAL HISTORY

Name of Physician: _____ Phone: _____

Date of last physical: _____

Does your child have any allergies? YES ☐ NO ☐

If yes, please list: _____

Please check all of the conditions your child has.

- ☐ Abnormal bleeding or bruising
- ☐ Acid Reflex / Digestive Disorders
- ☐ AIDS or HIV
- ☐ Anxiety attacks
- ☐ Asthma / Hay Fever
- ☐ Broken jaw
- ☐ Cancer / Chemotherapy / Radiation
- ☐ CPAP user
- ☐ Diabetes
- ☐ Epilepsy / Seizure Disorder
- ☐ Gag Easily
- ☐ Heart Murmur / Heart Condition
- ☐ Hepatitis A, B, C
- ☐ Hyper (hypo) glycemia
- ☐ Liver Disease
- ☐ Lung disease / Tuberculosis
- ☐ Lupus
- ☐ Mental or Nervous disorders
- ☐ Mouth Breather
- ☐ Sleep Apnea / Sleep Disorder
- ☐ Snore when sleeping
- ☐ Ulcers
- ☐ Other _____

Describe any current medical treatment , impending surgery, gentic/development delay or other treatment that may possibly affect your childs dental treatment (i. e. Botox, Collagen injections).

List all medications, supplements, and or vitamins that your cild is currently taking.

Drug	Purpose	Drug	Purpose

IMPORTANT!
WE WOULD LIKE TO PROVIDE THE BEST TREATMENT OPTIONS AVAILABLE TO YOU BASED ON CURRENT AND ACCURATE INFORMATION. PLEASE ADVISE US OF ANY CHANGES IN MEDICATIONS OR TREATMENTS YOU HAVE UNDERGONE SINCE YOUR LAST VISIT.

APPOINTMENT CHANGE POLICY & PAYMENT

** **We have reserved this appointment time for your child, if you need to alter your appointment, please provide our office with a minimum of 48 hours advance notice during business hours to avoid a cancellation fee.**

** I hereby authorize my insurance benfits to be paid directly to the dentist. I understand that any portion not paid by my insurance company within 30 days will be my responsibility and will be **taken from my credit card directly.**

** I authorize the dentist to release information for any claim to my insurance company.

** I certify that I have read the contents of this form and I understand what is expected of me and my child. I have completed this form accurately to the best of my knowledge.

PATIENT / GUARDIAN SIGNATURE **DATE**

_____ _____

WHISTLER DENTAL INSURANCE INFORMATION

As a courtesy and convenience to you, Whistler Dental accepts dental insurance plans upon confirmation of your coverage and allowable treatment. Based on this information, we are able to provide you with estimates of treatment required to the best of our knowledge. If we cannot get confirmtion of coverage and allowable treatment BEFORE your appointment, patients are required to pay the FULL amount at the time of treatment.

Your dental policy is a contract between you, your employer and your insurance company. Should your coverage terminate or change in any way, we can only be notified of the by YOU, the patient. If treatment is not paid by your dental plan, it is the SOLE responsibility of you, the patient, to cover ALL costs. If your insurance company denies treatment, Whistler Dental will not resubmit insurance claims on your behaf and will then become your responsibiliy.

We will try our best to keep track of your hygiene frequency but it is ultimately your responsibility to know your recare/hygiene coverage intervals. Whistler Dental will not be responsibe if treatment is not covered due to “early cleaning” appointments.

In order for us to accept your insurnce plan, we will require a valid credit card to remain on file for any treatment that is not covered by your insurance company.

We bill all treatment done on the day the service is rendered. If we have not received payment from your insurance company plan within 30 days of services rendered, then the claim becomes your responsibilty. Any portion of any claim submitted to you insurance company that is not paid within 30 days will be your responsibility will be charged to your credit card automatically.

If you require any assistance with your insurance, please speak with one of out staff; we would be more than happy to help.

I have read and understand the above and agree with the terms and conditions.

Credit card information: Visa ___ Mastercard ___
Name on Card: _____
Card Number: _____
Expiry Date: _____ 3 Digit Code: _____

Patient Name (please print): _____
Signature _____ Date: _____
Patient ( ) Parent ( ) Guardian ( )

****Note all credit card information is kept confidential**