PRAIRIE ROOTS
DENTAL STUDIO

Child Questionnaire

First name: _____Last name: _____Preferred name:_____

Date of Birth: _____ Age: _____ Male ☐ Female ☐

Address: _____ City: _____ Province: ____ Postal Code: _____

Name of Parent(s) or Guardian(s):_____

Cell phone: _____ Home phone: _____ Work phone: _____ Ext _____

Name of School: _____ Grade: _____

Do you have any pets, hobbies or special interests? Yes ☐ No ☐ If yes, please comment below: _____
Are there other family members presently at our office? Yes ☐ No ☐ If yes, please comment: _____

Is there any other information you believe would be helpful to us? Yes ☐ No ☐
Please comment: _____

Preferred Method of Contact: Cell phone ☐ Home phone ☐ Work phone ☐ Email ☐

Email address: _____

Dental History

Name of previous dentist/office: _____Phone number:_____

Date of last dental visit: _____ Reason for visit: _____

Reason for changing dentists: _____

Is this office visit for emergency dental care? Yes: ☐ No: ☐

If yes, please explain: _____

Is this office visit for emergency dental care? Yes: ☐ No: ☐

If yes, please explain why: _____

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Primary Insurance Provider:

Name of insurance company or government program: _____

Name of policy holder: _____Date of birth: _____

Relationship to policy holder: Self ☐ Spouse ☐ Dependent ☐ Other ☐

Group/Plan #: _____ Certificate/ID #: _____

Treaty number/Health card number (if government insurance): _____

Annual deductible: $_____ Annual maximum: $_____ Basic: %_____ Major: %_____

Secondary Insurance Provider:

Name of insurance company or government program: _____

Name of policy holder: _____Date of birth: _____

Relationship to policy holder: Self ☐ Spouse ☐ Dependent ☐ Other ☐

Group/Plan #: _____ Certificate/ID #: _____

Treaty number/Health card number (if government insurance): _____

Annual deductible: $_____ Annual maximum: $_____ Basic: %_____ Major: %_____

☐ I would like to pay at the time of my treatment and have my insurance company reimburse me directly (non-assignment).

☐ I would like the insurance company to pay the dentist directly (assignment). I understand that I am responsible for any and all amounts not covered by my insurance plan, no matter the reason.

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Please check the reason(s) for seeking dental care:

Routine checkup	☐	Swelling of face	☐	Bleeding around mouth	☐
New examination	☐	Crowding of teeth	☐	Other: _____	
Toothache	☐	Appearance of teeth	☐		

Has your child had any serious trouble associated with any previous dental treatment? Yes ☐ No ☐
If yes, please explain: _____

Has there been a previous facial or dental injury? Yes ☐ No ☐ If yes, what was the cause of the accident? _____
_____ At what age? _____ Which teeth were involved? _____

If there are any of the following habits, please check:
Lip sucking/biting ☐ Thumb/finger sucking ☐ Nail biting ☐

Is your child presently under observation or treatment for any condition? Yes: ☐ No: ☐
If yes, please explain_____

Is your child currently taking any medications, whether prescribed or non-prescribed? This includes Aspirin, cold remedies and antibiotics. Please specify: _____

Does your child have, or has your child ever had, any medical disorder, including:

Heart problems	☐	Seizure disorders	☐	Thalassemia	☐
Sickle cell anemia	☐	Emotional/mental disorders	☐	Diabetes	☐
Heart surgery	☐	Congenital defects	☐	Chicken Pox	☐
Hemophilia	☐	Hepatitis/other liver disorders	☐	Strep Throat	☐

Allergies ☐ Please specify: _____

Any other condition not listed above: _____
Does your child bruise easily or bleed profusely for a long period of time? Yes: ☐ No: ☐
Has your child ever had surgery/x-ray treatment for any tumor, growth or other condition?
Yes: ☐ No: ☐ If yes, please explain: _____
Has your child ever been hospitalized for any reason? Yes: ☐ No: ☐
If yes, please explain: _____
Has your child had general or local anesthetic? Yes: ☐ No: ☐

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Signature: _____ Date: _____

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Consent for Service

I consent to the performing of dental and oral surgery procedures including the use of local anesthetic and other medications as indicated.

I accept that all emergency dental service, or any dental services performed without previous financial arrangements, must be paid for all the time the services are performed.

I understand that I am to pay my estimated patient portion at the time of my treatment and that I am financially responsible for any and all further charges not paid for by my dental insurance. As a professional courtesy this office will prepare patient insurance forms, make collections from insurance companies and will credit any such collections to the patient's account. However, if the insurance information provided to us is incorrect this office cannot be responsible for outstanding balances. Any outstanding balances are the sole responsibility of the patient.

I understand that any fee estimated provided for dental care can only be extended for a period of three months from the date of the patient examination.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I understand that the information gathered on this form and in subsequent visits may be used to contact me at my home or work to discuss matters related to this form, discuss treatment needs or outcomes, and correspond with other health care providers who may participate in my treatment. Digital photos and x-rays may be used for educational purposes or presentations while guaranteeing my anonymity. My personal information will not be given to anyone for any other purpose unless required by law.

Signature: _____ Date: _____

We understand that unforeseen circumstances arise, but individuals who show a repeated disregard for our time and the time of our other patients by showing up late, cancelling without 24 hour notice or failing to show up for their appointment may be advised to seek dental care elsewhere.