Kidsteeth
Dentistry for Children

Dr. Diederik W. Millenaar, Inc.
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New Patient Form

Please complete this form digitally and email to contact@kidsteeth.ca or print, complete and bring it with you to our office on your first visit.

Patient Name _____ Gender _____
Date of Birth _____ MSP Card # _____
Phone _____ Address _____
Email _____

Parent/Guardian Information

Mother/Guardian: _____ Father/Guardian _____
Date of Birth _____ Date of Birth _____
Insurance Provider _____ Insurance Provider _____
Employer _____ Employer _____
Policy # _____ Policy # _____
ID # _____ ID # _____
Your plan limit? Per person or per family? _____
Percentage coverage (Basic or specialist fees)? _____
Are exams 6 or 9 months apart? _____
Is there a deductible? _____
Do they pay for oral sedation (code 92424)? _____

Medical History

Does or did your child have any of the following? (please check if positive.)

ADHD	☐	Developmental Delay	☐	Liver/Kidney Disease	☐
Asthma	☐	Hepatitis	☐	Premature Birth	☐
Autism	☐	Heart Disease/Murmur	☐	Seizure/Epilepsy	☐
Cancer	☐	Hemophilia/Blood Disorder	☐	Special Needs	☐
Congenital Birth Defect	☐	HIV/AIDS	☐	Tuberculosis	☐
Diabetes	☐	Other:	_____		

Current Medications _____ Previous Hospitalizations _____
Allergies _____ Immunizations up to date Yes ☐ No ☐

Dental History

Is this your child's first visit to a dentist? Yes ☐ No ☐

If no, who was the last dentist? _____

Chief dental concern _____

Date of most recent checkup _____ Last X-ray _____

Do you brush your child's teeth? Yes ☐ No ☐ How often? _____

Do you floss your child's teeth Yes ☐ No ☐ How often? _____

Past negative dental experience Yes ☐ No ☐ Explain _____

Experiencing current dental pain? Yes ☐ No ☐ Explain _____

Have there been injuries to Teeth ☐ Mouth ☐ Face ☐ Explain _____

Habits Nail Biting ☐ Nursing/Bottle Habit ☐ Thumb/Finger/Soother Habit ☐

Personal Information Protection Act Consent

I hereby authorize Dr. Diederik W. Millenaar, Inc. ("Kidsteeth") to collect, disclose and use information provided by me to communicate with other health professionals, such as dentists and doctors, on my and my child's behalf; to communicate with insurance providers on my behalf to obtain estimate and pre-authorization of treatment.

Parent/Guardian Signature _____

Financial Responsibility Agreement

I acknowledge that I am financially responsible for all charges. As a courtesy to patients, insurance will be direct billed by Dr. Diederik W. Millenaar, Inc. **We follow the current B.C. Pediatric Dentistry Fee Guide.** I am responsible for 100% of all fees that are not covered by my insurance policy. I will be provided with an estimate of the fee for services recommended based on the initial treatment plan. However, I understand the actual treatment provided may be different from an estimated treatment plan. Dr. Diederik W. Millenaar, Inc. reserves the right to charge a deposit for treatment appointments.

Parent/Guardian Signature _____

Cancellation and No Show Policy

If I am unable to commit to my scheduled appointment and fail to give a 2 business days cancellation notice ahead of time, I understand I will be charged $50 for the appointment for new patient exam, consultation and check-ups. For sedation and general anesthesia appointment, short notice cancellation, no show or violation of pre-op instructions will result in loss of my deposit.

Parent/Guardian Signature _____

Examination Consent

I understand that my child may have dental needs that require examination and possible treatment. I acknowledge and consent to my child being examined by Dr. Millenaar and staff for the purpose of determining my child's oral health status. This includes xrays, if indicated.

Parent/Guardian Signature _____

Verification of Information

I, the undersigned, declare that all of information provided is true to the best of my knowledge, and I have not knowingly omitted any information. My signature indicates that I have read all print and understand its content.

Parent/Guardian Signature _____ **Date** _____