



CHILD NEW PATIENT FORM (0–15 Years)

Fields marked with * are mandatory

Child Information

Patient Name*: _____ Nickname: _____

Date of Birth (MM/DD/YYYY)*: ____ / ____ / ____ Gender*: ☐ Male ☐ Female ☐ Prefer not to say

Parent / Guardian Information

Parent/Guardian Name*: _____

Email*: _____

Home Phone*: _____ Cell Phone*: _____

Address*: _____

Emergency Contact

Name*: _____

Relationship to Patient*: _____ Phone*: _____

How did you hear about our office?

Medical History

Please list any medical conditions and medication.

Name of Paediatrician or primary care physician _____

Last medical exam _____

Is the patient currently taking any medications? If so, please list the medications:



Has the patient recently been under the care of a physician? ☐ Yes ☐ No

If so, for what reason and what is the name of the physician?

Has the patient ever been hospitalized in the last 5 years? (if yes, please explain)

Has the patient had a serious illness or operation? (if yes, please explain)

Has your child had a history of being under oxygen/general anesthesia? ☐ Yes ☐ No

If so, any reactions or adverse effects? ☐ Yes ☐ No

Dental History

Previous Dental Clinic: _____ Phone: _____

Last dental visit: _____

Has the patient ever had difficulties in the dental office? (if yes, please explain)

Do you have any concerns with your child's teeth? If yes, please explain

Does the child have a specific problem that needs attention? If so, please check if applicable

☐ Toothache ☐ Orthodontics ☐ Home Care instructions

Is your child a mouth breather? ☐ Yes ☐ No If so, when: ☐ While asleep ☐ While awake

Has your child ever had any injury to the face, mouth or teeth? If yes, please explain

Has your child experienced popping, clicking or limitation of movement in temporomandibular joint (TMJ) ?

☐ Yes ☐ No

Does your child experience headaches on a regular basis? ☐ Yes ☐ No

Habits

☐ Nail biting ☐ Thumb Sucking ☐ Speech problems ☐ Tongue thrust ☐ Snoring



Insurance

Do you have dental insurance?* ☐ Yes ☐ No

Primary Insurance Company: _____

Policy #: _____ Certificate #: _____

Subscriber Relationship: _____ DOB (MM/DD/YYYY)*: ____ / ____ / ____

Secondary Insurance (if applicable): _____

Secondary Policy #: _____ Secondary Certificate #: _____

Subscriber Relationship: _____ DOB (MM/DD/YYYY)*: ____ / ____ / ____

Consent

I give my consent for the dentist of this office to do a complete/emergency oral dental examination on the patient listed above. Xrays that are necessary to properly complete the exam may be taken. If a cleaning, fluoride treatment and oral hygiene instructions are to be included in the first examination, I will be informed. Any additional treatment received will be fully explained prior to starting treatment at each visit. I agree to inform the doctors of any changes in medical or Insurance information.

I authorize the release of any information relating to any dental claims and understand that I am personally responsible for all costs associated for the dental treatment that is performed on my child. By signing this, I agree that the medical history is filled out to the best of my knowledge and I accept financial responsibility for my child.

PATIENT CONSENT: The privacy of your personal information is a priority in our commitment to providing highquality dental care. We recognize the importance of safeguarding your personal data and are dedicated to handling it responsibly, ensuring its collection, use, and disclosure are managed with the utmost care. All staff members who have access to your personal information are thoroughly trained in its proper handling and protection. In this consent form, we have detailed the measures our office takes to ensure that:

- Only the necessary information is collected from you.
- Your information is shared exclusively with your consent.
- The storage, retention, and destruction of your personal information adhere to applicable legislation and privacy protocols.
- Our privacy practices are fully compliant with the privacy standards set forth by our regulatory body, the Royal College of Dental Surgeons of Ontario, as well as relevant laws.

This office will collect, use and disclose information about you for the following purposes:

- To provide safe and efficient patient care.
- To ensure continuous highquality service.
- To assess your health needs.
- To deliver appropriate healthcare services.
- To inform you of available treatment options.



- To facilitate communication, including scheduling and confirming appointments, followups, and billing matters.
- To offer and provide treatment and care related to the oral and maxillofacial complex and general dental care.
- To communicate with other healthcare providers, including specialists and referring or peripheral dentists.
- To submit dental claims for thirdparty adjudication and payment.
- To meet legal and regulatory obligations, including providing patient records to the Royal College of Dental Surgeons of Ontario as required by the Regulated Health Professions Act.
- To deliver patient charts and records to the dentist's insurance carrier for liability assessment and damage quantification, if applicable.
- To prepare documentation for the Health Professions Appeal and Review Board (HPARB).
- To allow potential purchasers, practice brokers, or advisors to assess the practice or conduct an audit in preparation for a practice sale.
- To invoice for goods and services.
- To process credit card payments.
- To collect outstanding accounts.
- To ensure compliance with regulatory requirements.
- To comply with applicable laws and regulations.

Your information may be accessed by regulatory authorities by the Regulated Health Professions Act (RHPA) to enable the Royal College of Dental Surgeons of Ontario to fulfill its mandate under the RHPA, as well as for the defence of any legal matters.

Under no circumstances will our office provide your insurer with your confidential medical history. If such a request is made, we will promptly forward the information to you for review and obtain your explicit consent before any disclosure.

When we receive unusual requests for your information, we will contact you to obtain your permission before releasing any data. Additionally, we may inform you if we believe that such a release would be inappropriate. You have the right to withdraw your consent for the use or disclosure of your personal health information at any time.

PATIENT CONSENT: I have reviewed the information provided above, which outlines how your office will use my personal information and the measures being taken to protect it. I consent to Gumtree Dental Care collecting, using, and disclosing my personal information to the following individual(s).

Write your signature below.

Signature

Print Full Name _____ Date _____

I understand that Protected Health Information (PHI) or sensitive information should not be included in this message.