Dr. William Rodriguez
DENTISTRY PROFESSIONAL CORPORATION

Child Patient Information

Parent or Guardian: Please provide information about yourself on the reverse side of this form. To help us provide your child with the highest quality dental care and to ensure his/her comfort and safety while at The SMILE Centre, please answer the following questions in detail. The information you provide in this form is considered confidential and for our records only. If you have any questions or would like assistance in filling out this form, please let us know.

Child ☐ Adult with Guardianship ☐ Nickname ______

Last Name ______ First Name ______ Middle Name ______

Address ______

______

Telephone: Home ______ Business ______ Fax ______

Date of Birth ______ Marital Status ______ Gender: ☐ Male ☐ Female

Who is financially responsible for this account? ______

Whom may we thank for referring you to The SMILE Centre? ______

Employer ______ S.I.N. ______

Do you have any dental insurance?

☐ Yes (Please complete insurance information on reverse.) ☐ No

In case of emergency, please notify ______ Telephone No. ______

Is any other member of your family a patient at The SMILE Centre? ______

Health Questionnaire

Date of Last Visit to a Physician ______

Physician's Name ______ Telephone No. ______

Present Medication (Prescribed) ______ Non-Prescribed ______

Recent Medication (Last 6 Months) ______

Past and Present Illnesses (If you are not sure of the answer, please put a question mark next to the question.)

	Yes	No		Yes	No
Have you had any serious illnesses?			Kidney problems		
Have you ever been hospitalized?			Venereal diseases		
Cardiac problems			AIDS		
Rheumatic heart disease			Diabetes		
Prolonged bleeding			Thyroid problems		
Anemia			Eye problems		
High ☐ Low ☐ blood pressure			Epilepsy		
Tuberculosis ☐ Pulmonary problems ☐			Mental problems		
Gastro-intestinal problems			Loss of consciousness		
Liver problems (Hepatitis ☐ Cirrhosis ☐)			Radiotherapy		
Are you pregnant? Months ______			Allergy		

Any positive answer should be explained ______

Precautions ______

Weight ______ Height ______

I, the undersigned, declare that I have read and understood this health questionnaire and have answered it to the best of my knowledge.

Signature of Parent/Guardian ______ Date ______

1st Insurance Information

Subscriber's Title: Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

Subscriber's Last Name ____________ First Name ____________ Middle Name ____________

Subscriber's Relationship to Patient ____________

Subscriber's Employer ____________ Employee No. ____________

Subscriber's S.I.N. ____________ Subscriber's Date of Birth ____________

Insurance Company ____________ Policy/Group/Plan No. ____________

Division/Section No. ____________ Certificate No. ____________

2nd Insurance Information

Subscriber's Title: Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

Subscriber's Last Name ____________ First Name ____________ Middle Name ____________

Subscriber's Relationship to Patient ____________

Subscriber's Employer ____________ Employee No. ____________

Subscriber's S.I.N. ____________ Subscriber's Date of Birth ____________

Insurance Company ____________ Policy/Group/Plan No. ____________

Division/Section No. ____________ Certificate No. ____________

Subscriber Authorization for Electronic Filing of Claims

The Executive Council of the Canadian Dental Association requires us to obtain your signature authorizing The Smile Centre to submit claims electronically. This authorization form will be kept in your chart.

I authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically.

____

Signature of Subscriber

I hereby assign my benefits payable from claims submitted electronically to The Smile Centre and authorize payment directly to The Smile Centre.

____

Signature of Subscriber

Parent/Guardian Information

Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐

Last Name ____________ First Name ____________ Middle Name ____________

Relationship to Patient ____________

Address ____________

____

Telephone: Home ____________ Business ____________ Fax ____________

Marital Status ____________ Employer ____________ S.I.N. ____________