glow

Welcome to Glow! We take a human approach that puts you and your family first. Our passion is making people feel confident about their teeth.
Please fill the form completely and accurately.
You can send the completed form to **hello@smilesbyglow.ca** or bring it with you to the first appointment.

Patient Information

Patient Name: _____ Preferred Name: _____
Birthdate (MM/DD/YY): _____ /_____ /_____ Age: _____ Gender: ☐M ☐F
Address: _____ Postal code: _____
Home Phone: _____ MSP Card #: _____
School: _____ Sibling Name(s) / Age(s): _____

Parent/Guardian Information

Parent 1: _____ Parent 2: _____
Birthdate (MM/DD/YY): _____ /_____ /_____ Birthdate (MM/DD/YY): _____ /_____ /_____
Phone (Cell): _____ Phone (Cell): _____
Email: _____ Email: _____
Employer: _____ Employer: _____
Occupation: _____ Occupation: _____
Insurance Co: _____ Insurance Co: _____
Policy#:_____ ID#:_____ Policy#:_____ ID#:_____

Medical History

Physician: _____ Date of Last Visit: _____
Name of Practice: _____ Physician Tel: _____
Are Immunizations Up to Date? ☐Yes ☐No - If no, please explain why _____
Has your child ever been treated for any of the following (please circle all that apply):
☐ ADHD ☐Asthma ☐Anxiety/Depression ☐Autism ☐Bleeding/Blood disorder ☐Bone disorder
☐ Cancer ☐Congenital birth defect ☐Diabetes ☐Developmental Delay ☐Heart disease / murmur
☐ Hearing problems ☐HIV/AIDS ☐Kidney disease ☐Learning disabilities ☐Liver disease / Hepatitis
☐ Lung disease ☐Premature birth ☐Rheumatic Fever ☐Seizure / Epilepsy ☐Vision problems
Please provide details as needed or other disease, conditions, syndromes not listed above:
_____
Current Medication: _____
List any allergies to foods, medications, or latex: _____
Is there anything else we should know about your child? _____

Dental History

Chief Dental Complaint: _____
Has your child been to a dentist previously? ☐Yes ☐No
Name of the Previous Dentist: _____
Last Check-Up and Cleaning: _____ Last X-Rays Taken: _____
Past Negative Dental Experience? ☐Yes ☐No

Referrals - We'd love to say thank you!

How did you hear about us? ☐Dentist ☐Friend ☐Google ☐Social Media Other_____
Referred by: _____

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Personal Information Protection Act Consent

I hereby authorize Dr. T. H. Rhee Inc ("Glow Pediatric Dentistry and Orthodontics") to collect, disclose and use information provided by me to communicate with other health professionals on my and my child's behalf; to communicate with insurance providers on my behalf to obtain estimate and pre-authorization of treatment; and to communicate related services and activities provided by as a newsletter or appointment reminder emails.

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 Glow Pediatric Dentistry and Orthodontics. 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 service recommended based on initial treatment plan. However, I understand the actual treatment provided may be different from an estimated treatment plan. Glow Pediatric Dentistry and Orthodontics 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 48 hour cancellation notice ahead of time, I understand that I will be charged $75** 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 _____

Authorization for Credit Card Use

Glow Pediatric Dentistry and Orthodontics may collect your credit card information such as credit card type, credit card number, expiration date and card identification number. I authorize Glow Pediatric Dentistry and Orthodontics to charge the outstanding balance to the credit card provided. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Parent/Guardian Signature _____

Photography and Video Waiver

At Glow Pediatric Dentistry and Orthodontics, we would like to connect with our patients and families even when you are not in our office. We may take photographs or videos to record the treatment progress or to showcase our patients enjoying themselves in our office or at our events. Examples include pictures of patients on our office wall, on our Facebook or on Instagram. We will not post any photos or videos without your consent.

I allow Glow Pediatric Dentistry and Orthodontics to take photographs and videos and copyright, use and reproduce them in educational, news or promotional material, whether in print, electronic or other media, including the smilesbyglow.ca website. I grant to Glow Pediatric Dentistry and Orthodontics the right to use the name, testimonial, voice, image, and other information of both myself and my child for such purposes. All postings become the sole property of Glow Pediatric Dentistry and Orthodontics. Postings may be displayed, distributed, or used by Glow Pediatric Dentistry and Orthodontics for any purpose whether in whole, part or composite form, electronic, or digital. I agree that no material need be submitted to me for any further approval. I hereby release Glow Pediatric Dentistry and Orthodontics and their successors and assigns, employee, directors and officers and agents from any and all claims arising out of their use of my name, testimonial, voice, image, and biography as agreed to in this document, including without limitation any claims based on the right of publicity or privacy.

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** _____

Witness Name _____ **Signature** _____