Pediatric Dentistry ON 160

Welcome to our Clinic

Patient Name: _____ Gender: ○ F ○ M

Alberta Health Care #: _____ Date of Birth (DD/MM/YYYY): _____

Parents/Legal Guardians Names: _____

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

Main Phone Number: _____ Alternate Phone Number: _____

Email: _____

In case of emergency, we should notfiy (other than parent);

Full Name: _____ Relationship: _____

Phone Number: _____

Name of Family Physician/Pediatrician: _____

Address: _____ Phone Number: _____

Whom shall we thank for your referral? _____

We require the following information to provide your child with the best possible dental care. All information is strictly private and is protected in accordance with the HIPAA Privacy Act. Please fill the entire form to the best of your ability.

Medical Questionnaire

Is your child under the care of a physician at present? ○ Yes ○ No

If yes, since when and for what reason? _____

Is your child allergic or had a reaction to any medicine or food? ○ Yes ○ No

If yes, please list: _____

Is your child receiving prescribed medication? ○ Yes ○ No

If yes, please list: _____

Questionnaire continues on next page >

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Have you ever been told that your child has any of the following conditions? Please check all that apply.

☐ Allergies ☐ Anemia ☐ Arthritis ☐ Autism ☐ Birth Defects ☐ Bleeding ☐ Blood Transfusions ☐ Brain Injury
☐ Cancer ☐ Cerebral Palsy ☐ Chicken Pox ☐ Child Abuse ☐ Cleft Lip/Palate ☐ Diabetes ☐ Developmental Delay
☐ Epilepsy ☐ Eyesight Problems ☐ Fainting ☐ Headaches ☐ Hearing Loss ☐ Heart Trouble ☐ Hemophilia
☐ Hepatitis ☐ High Blood Pressure ☐ Hyperactive ☐ Latex Allergy ☐ Leukemia ☐ Liver Problems ☐ Lung Problems
☐ Kidney Problems ☐ Malignant Hyperthermia ☐ Nutritional Deficiency ☐ Physical Handicap ☐ Pneumonia
☐ Seizures ☐ Speech Problems ☐ Tuberculosis ☐ Other: _____

Has your child has a new cough, fever and/or chills within the past 24 hours? ○ Yes ○ No

Does your child have any other medical, psychiatric or developmental conditions we should know about?

Please specify: _____

Are your child's immunizations up to date? ○ Yes ○ No

Dental History

Has your child had previous dental treatment? ○ Yes ○ No

If yes, how long ago? _____

Has your child ever had an unpleasant dental experience? ○ Yes ○ No

If yes, please explain _____

Have there been any injuries to the teeth or mouth? ○ Yes ○ No

If yes, please explain _____

Has your child ever received any of the following? ☐ Sedation ☐ Nitrous Oxide (Laughing Gas) ☐ General Anesthesia

Dental Disease Prevention

When does your child brush his/her teeth? ☐ Infrequently ☐ Morning ☐ After Eating Any Food ☐ Right After Meals ☐ Before Going to Bed

Does your child use dental floss? ○ Yes ○ No

Does someone assist your child with brushing/flossing? ○ Yes ○ No

Where is the brushing done? ☐ Bathroom ☐ Counter-top ☐ In a laid back position ☐ Other: _____

How was your child fed as an infant? ☐ Breastfeeding ☐ Bottle-feeding ☐ Sippy Cup

Frequency of snacks per day? ☐ 2 times a day ☐ 3 times a day ☐ More than 3 times a day

Examples of snacks: _____

Does your child use a toothpaste containing fluoride? ○ Yes ○ No

Have you ever been taught how to brush/floss? ○ Yes ○ No

Does/did your child ever have any of the following? Please check all that apply.

☐ Thumb/Finger Sucking ☐ Bad Breath ☐ Lip Biting ☐ Tongue Thrusting ☐ Bottle in Bed ☐ Teeth Grinding
☐ Mouth Breathing ☐ Pacifier Use ☐ Drooling ☐ Snoring ☐ Lisping ☐ Stuttering ☐ Gagging ☐ Cold Sores

Any other information we should be aware of? _____

To the best of my knowledge, the above information is correct.

Parent/Legal Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

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Dental Coverage Information

Insurance companies are put in order of birth month. All benefits through the government can be entered at the bottom of the page.

Primary Insurance Information

Card Holder's Name: _____ Date of Birth (DD/MM/YYYY): _____

Employer: _____ Name of Insurance Company: _____

Policy/Group #: _____ Certificate/ID #: _____

Secondary Insurance Information

Card Holder's Name: _____ Date of Birth (DD/MM/YYYY): _____

Employer: _____ Name of Insurance Company: _____

Policy/Group #: _____ Certificate/ID #: _____

Government Benefits

First Canadian Health (Treaty), AISH, Child Health Benefits, or Alberta Works

Child's Name: _____ Date of Birth (DD/MM/YYYY): _____

Government ID/Treaty #: _____

Child's Name: _____ Date of Birth (DD/MM/YYYY): _____

Government ID/Treaty #: _____

Child's Name: _____ Date of Birth (DD/MM/YYYY): _____

Government ID/Treaty #: _____

Please let our office know if there are any additional insurances or if you have any questions regarding your insurance or claim submissions.

It is your responsibility to ensure that your insurance coverage is active the day of treatment.

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Information Consent Form

We are committed to protecting the privacy of our patients personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers and email addresses (collectively referred to as "contact information"). Contact information is collected and used for the following purposes:

- To open and update patient files, to send reminders regarding dental cleanings
- To invoice patients for dental services, to process credit card payments or to collect unpaid accounts
- To process claims for payment or reimbursement from third party health benefit providers and insurance companies

Contact information is disclosed to third party health benefit providers and insurance companies where a claim has been submitted by our office for payment of all or part of the cost of dental treatment, or has asked us to resubmit a claim on the patients behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical conditions and dental treatments (collectively referred to as "Medical Information"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed:

- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion
- To other dentists and dental specialists if the patient, with his/her consent, has been referred by us to the other dentist or dental specialist for treatment
- To other dentists and dental specialists where those dentist have asked us, with the consent of the patient, to provide a second opinion
- To other health care professionals, such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information, in order to verify information important to the potential sale. If this occurs, we will take steps to ensure the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal information as set out above.

Date: _____ Print Name:_____ Signature: _____

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Office Policy Form

Treatment Policy

We are committed to providing the highest standard of dental care for our patients. Our goal is to help your child develop a positive attitude towards their oral health and towards their dental experience.

We ask that a parent or legal guardian be present at all appointments. Children who are not receiving care must either be left under the supervision of an adult in the waiting room or at home.

Please consider...

Parents and/or guardians should be a positive but mainly quiet support for the child during dental treatment. Please refrain from overwhelming the child with information or comments such as, "Will there be needles?", "Don't worry, you won't feel a thing!" or "Hold still, almost done." Direction and information will be provided gently and as necessary to the patient by Dr. Kurji or Dr. Wong and the dental staff. At times, a parent's anxiety can transfer to the child unknowingly. Please allow your child to gain confidence and independence by following directions set out by Dr. Kurji or Dr. Wong. It is very important that parents are in sync with the dental team in order to provide a happy and relaxed environment for everyone.

Cancellation Policy

We kindly ask that you provide us with **2 Business Days** notice if you are unable to attend your scheduled appointment. Please note that if you do not provide sufficient notice on 2 occasions, we will be unable to accommodate future appointments for the child.

Note: If an appointment is missed without the indicate notice, there will be $50.00 cancellation fee.

Billing & Payment

As a courtesy to our patients we accept direct billing to insurance companies. Direct billing refers to a dental office accepting payments from insurance companies and allowing the parents/guardians to pay only the portion not covered by the insurance plan. **It is in your best interest to be aware of your dental benefit plan and its limitations.**

We are here to assist you.
Some things to be aware of are:

- Annual maximum
- Amount of money you have used at a previous office/offices
- Allowed frequency of procedures
- Coverage of dental procedures (many dental plans do not cover standard dental procedures)
- **Nitrous oxide (laughing gas) and general anaesthesia may not be covered by your dental plan**

All billings and payments are completed on the date of service rendered. This means that all portions not covered by the insurance are due in full on the date of the appointment or ***prior to,*** depending on the treatment. If we do not know your portion on the date of service, we will collect a portion (up to 30%) of the total amount. **If we cannot verify your coverage before your appointment, we cannot direct bill and you will be required to pay in full for your treatment.** For some treatment a deposit will be required in advance and we will let you know if this is the case. If your account balance is not paid in full within 4 weeks of treatment rendered, you will be responsible for any additional costs incurred for attempting to collect these funds.

Note: If in the future our office determines that it is not feasible to continue to accept direct billing, we may have to change our policy on billings and payments. We will provide ample notice if our office policy is to change.

Any amount not covered by your insurance for whatever reason, is your responsibility. **Insurance coverage is between you and your insurance provider.** As a dental care provider, the focus is on the best possible dental treatment. If you would like, our office can send a predetermination to your insurance company to estimate your portion. For your convenience we accept debit, Visa, MasterCard, cash, and e-Transfers.

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