Gateway Pediatric Dentistry Medical and Dental History

Date:_____ Patient Name:(Last)_____(First)_____(Preferred)_____

Birth date :(DD/MM/YYYY)_____ □ Male □ Female

Name of person completing this form: _____

Relationship to patient: □ Parent □ Guardian □ Other:_____

Mother/Father's name: _____ Mother/Father's name:_____

Home address:_____City_____

Province_____Postal Code:_____ Child's Alberta Health Care#:_____

EMAIL Address:_____ Physician: _____

Mobile Phone Number:_____ Alternate Phone Number :_____

Dental Insurance (**Mother/Father**)

Employer Name:
Insurance Co. Name
Group/Policy Number:
Employees Certificate #_____/ID#
Date of Birth: (DD/MM/YY)_____

Dental Insurance (**Mother/Father**)

Employer Name:
Insurance Co. Name:
Group/Policy Number:
Employees Certificate #_____ /ID#
Date of Birth: (DD/MM/YY)_____

Were you referred to our office? □ Yes □ No If yes, by whom? _____

Do you have any special family circumstances, privacy requests or insurance policy concerns we should be aware of? □ Yes □ No Please describe_____

MEDICAL HISTORY

□ Yes □ No Is your child in good health? Date of last medical exam _____
□ Yes □ No Has your child ever had a health problem? _____
□ Yes □ No Is your child allergic to anything? _____
□ Yes □ No Is your child currently taking any medications? If yes, please provide medication, dose and reason:_____
□ Yes □ No Are your child's immunizations current? _____
□ Yes □ No Have you ever been told that your child needs to take antibiotics before dental treatment?
□ Yes □ No Has your child ever been hospitalized, had general anesthesia, or emergency room visits?
□ Yes □ No Were there any difficulties at birth or pre-mature?_____

Please check if your child has been treated for any of the following:

□ Heart disease	□ Heart murmur	□ Bleeding/transfusions	□ Asthma
□ Anemia	□ Blood disorders	□ Tonsil/adenoid problems	□ Tuberculosis
□ Liver Disease	□ Sickle cell disease	□ Diabetes	□ HIV/AIDS
□ Kidney disease	□ _____Syndrome	□ Hepatitis	□ Mental delays
□ Speech/hearing	□ Seizures	□ Cleft lip/palate	□ Physical delays
□ Eyesight	□ Congenital birth defects	□ Gastric disease / Reflux	□ Cancer/Tumors
□ Cerebral palsy	□ Significant injuries	□ Endocrine/growth	□ Autism
□ Arthritis	□ ADHD	□ Spina bifida	□ Snoring

Other:_____

Dental History

What is the reason for your child's dental visit?_____

□ Yes □ No Has your child ever been to the dentist? Date of last cleaning & x-rays(if taken)_____

□ Yes □ No Has your child experienced any unfavourable reaction from previous dental care?
Explain_____

□ Yes □ No Does your child suck a finger, thumb, or pacifier?

□ Yes □ No Does your child have pain with chewing, or while sleeping?

□ Yes □ No Does your child go to bed with a bottle or sippy cup?

□ Yes □ No Does your child snack frequently? Favourite snack foods? _____

□ Yes □ No Has your child had local anesthetic? Were there any problems?_____

□ Yes □ No Has your child been sedated for dental treatment? Were there any problems?_____

□ Yes □ No Have your child's teeth ever been injured? Which teeth?_____
Dental treatment for trauma:_____

Please check if your child is having problems with any of the following:

□ Cavities	□ Toothache	□ Sensitive teeth	□ Mouth breathing
□ Trauma	□ Gum Infections	□ Color of Teeth	□ Other
□ Orthodontics	□ Jaw Sounds	□ Grinding of Teeth	

Comments:_____

Consent for Dental Treatment

As the parent and/or legal guardian of the patient, I do hereby request and authorize Drs. Richard Graham, Adam Palmer, Maria Ray, Brian Lam and/or Simrit Nijjar and staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behaviour by helping them understand the treatment in terms appropriate for their age. Drs. Graham, Lam, Palmer, Nijjar and/or Ray will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Gateway Pediatric Dentistry of any changes in my child's medical status.

Legal Guardian's Signature: _____ **Date:** _____

GATEWAY PEDIATRIC DENTISTRY
PERSONAL INFORMATION CONSENT

We are committed to protecting the privacy of our patient's 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 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.
* To send reminders to patients concerning the need for further dental examination or treatment and/or appointment confirmations.
* To send patients informational material about our dental practice.

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's 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 condition, 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 third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.
* To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to use obtaining the second opinion.
* To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.

* To other dentists and dental specialists where those dentists 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 that 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.

To comply with the Canadian Anti-Spam Legislation (CASL) that is in effect as of July 1, 2014, our dental office would like to have your express consent to continue communicating with you and providing you with important information from us. We are committed to never sending spam emails and our privacy policy will always protect your electronic information. We do send information, communication via email and text for our patients' convenience.

If you decide to opt in and continue receiving emails, please know that you may opt out at any time and withdraw your consent.

____YES I give consent to receive communication and appointment confirmations via email and/or text.
____ NO I do not give consent. I prefer to receive telephone confirmations.

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

Parent/Legal Guardian: _____ Date: _____

Patient Name: _____

GATEWAY PEDIATRIC DENTISTRY OFFICE POLICIES

We would like to take this opportunity to welcome you to our practice and thank you for choosing our office to provide dental care for your child. We value our relationship with you and believe that the best relationships are based on understanding. If you have any questions or concerns please feel free to ask any member of our staff.

Payment

Payment is due for all treatment completed on the day the service is rendered. We accept MasterCard, Visa, Interact/debit, and Cash. We do not accept personal checks.

Dental Insurance

As a courtesy to you, our staff will complete the dental portion of the insurance claim form and submit to your insurance for your reimbursement. To expedite processing, please ensure you provide our office with any changes in insurance coverage, address and phone numbers.

Please be advised that dental insurance or benefits are a contract between you, your employer and your insurance company. Under the Privacy Act, the majority of insurance companies will not provide our office with any details regarding your coverage. We cannot influence how much of our fees your insurance will cover. Your insurance benefits are determined by your individual policy and carrier. Our objective as dental health care providers is to diagnose any treatment required according to each patient's particular needs. We do not know if your insurance will cover the treatment we diagnose, as this is only outlined in your policy handbook. You will be responsible for fees incurred and balances not covered by your insurance.

Nitrous oxide, conscious oral sedation, general anesthesia, and appliances are not always covered by dental or medical insurance.

If you require a "predetermination" we will provide a treatment plan for review by the third party payer. However, please remember that the financial obligation for treatment is between you and this office. The third party payer is responsible to you and not this office. If you require assistance in understanding your handbook, we would be happy to do so. Please be advised however, that a response from your insurance company may take four to six weeks to obtain.

Late or Missed Appointments

The time booked for your appointment has been reserved for you. We will contact you prior to your appointment to confirm the date and time. In consideration of our staff and other patients, **we require at least 24 hours or one business day notice on all cancellation or rescheduling of appointments**.

We look forward to providing you with excellent dental care. If you have any questions or concerns, please feel free to ask any of our staff.

Sincerely,

Dr. Richard Graham, Dr. Brian Lam, Dr. Adam Palmer, Dr. Simrit Nijjar and Dr. Maria Ray

I ACCEPT AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM.

Parent/ Legal Guardian Signature_____ Date: _____

Patient Name:_____

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