DENTIST

Dr John Miller
Dr Sam Goodman

Preventive | Cosmetic | Therapeutic

Child's Medical History Questionnaire

Date: _____

NAME:

Last: First: Middle:

Date of Birth (dd/mm/yyyy):

ADDRESS:

Street:

City: Prov: Postal Code:

GUARDIAN'S NAME:

Last: First:

Home: Cell: Business:

How would you like us to contact you? ☐Phone ☐Text Message ☐Email:

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name: Relationship to Child:

Day Time Phone:

FAMILY DOCTOR:

Name: Phone:

Address:

MEDICAL SPECIALIST:

Name: Area of Specialty:

Address (hospital): Phone:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the form to the best of your knowledge.

1. Is your child being treated for any medical condition at present or within the past year? ☐YES ☐NO

   If so, why? _____

2. Does your child take any medications, vitamins or supplements? ☐YES ☐NO

   If yes, what kind, dosage and reason?

   _____

3. Does your child have any allergies? If yes, please list below. ☐ YES ☐ NO

_____

4. Has your child ever been hospitalized, had general anesthesia or emergency room visits? ☐ YES ☐ NO

If yes, what for? _____

5. Have you ever been told that your child needs to take antibiotics before dental treatment? ☐ YES ☐ NO

6. Were there any difficulties at time of birth of your child (premature birth/infection,etc.)? ☐ YES ☐ NO

_____

7. Does your child have or had history of any of the following? (Please check all that apply):

☐ Diabetes	☐ Rheumatic fever	☐ Learning Disabilities	☐ Speech impairments
☐ Heart trouble	☐ Epilepsy	☐ Eyesight problems	☐ Hearing loss
☐ Seizures	☐ Cerebral palsy	☐ Cancer/tumors	
☐ Kidney Disease	☐ Liver Disease	☐ Abuse	
☐ Anemia	☐ Heart Murmur	☐ Sickle Cell Disease/Trait	
☐ HIV/AIDS	☐ Tuberculosis	☐ ADHD	
☐ Recurrent headaches	☐ Endocrine/growth	☐ Frequent Infections	
☐ Autism	☐ Hepatitis	☐ Congenital condition	
☐ Blood disorders	☐ Cleft Lip/Palate	☐ Tonsil/Adenoid Problems	
☐ Snoring	☐ Developmental Delays	☐ Prolonged Bleeding Episodes	
☐ Gastric Disease/Reflux	☐ Adverse Drug Reactions	☐ Arthritis	

Details of above conditions: _____

_____

_____

_____

8. Are there any conditions or diseases not listed that your child has or has had?

If yes, what? _____

_____

_____

To the best of my knowledge the above information is correct:

Patient/Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

"Creating a healthy smile through science and artistry"
12 Second Street, Collingwood, Ontario, L9Y 1E3
Tel: 705.444.2668 866.544.4792 Fax: 705.444.5847

CHILD'S DENTAL HISTORY QUESTIONNAIRE

Date: _____

Name of Child: _____

Name of Parent/Legal Guardian: _____

The following information is required to enable us to provide your child with the best possible dental care. All information is held strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Is this your child's first visit to the dentist? ☐ YES ☐ NO

   If not, when was the last visit to the dentist? _____

   Were any x-rays taken? If so, how long ago? _____

2. How often does your child eat sweets, such as candy, soda pop, and chewing gum?

   ☐ Often ☐ On Occasion ☐ Rarely ☐ Never

3. When does your child brush his/her teeth?

   ☐ In the morning ☐ After eating any food ☐ Right after meals ☐ before going to bed

4. Do you (or your child on his/her own) floss your child's teeth? ☐ YES ☐ NO

5. Does your child use fluoridated toothpaste? ☐ YES ☐ NO

6. Do you give your child fluoride supplements? ☐ YES ☐ NO

   If yes: How much? _____

7. Does your child suck a thumb, finger or pacifier? ☐ YES ☐ NO

8. Does your child go to bed with a bottle or sippy cup? ☐ YES ☐ NO

9. Does your child have tooth pain with chewing or while sleeping? ☐ YES ☐ NO

10. Have any cavities been noted in the past? ☐ YES ☐ NO

11. Has your child had dental fillings in the past? ☐ YES ☐ NO

12. Has your child ever had a local anesthetic / freezing? ☐ YES ☐ NO

13. Has your child had sedation in the past for dental treatment? If so, please indicate:

☐ Nitrous-Oxide ☐ Oral Sedation ☐ I.V. Sedation ☐ General Anesthetic

14. Has your child experienced any unfavorable reaction from previous dental care?

☐ YES ☐ NO

If yes: Details: _____

15. Have there been any injuries to teeth such as falls, chipped teeth, etc.? ☐ YES ☐ NO

If yes: Date of trauma? _____ Which tooth / teeth? _____

Details of trauma: _____

_____

16. Are you (or your child) interested in discussing orthodontics (braces)? ☐ YES ☐ NO

17. Has your child had orthodontic treatment (appliances, braces)? ☐ YES ☐ NO

If yes: Details & Name of orthodontist: _____

18. Is there anything else you would like us to know? _____

_____

Signature of Parent/Guardian: _____ Date: _____

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INSURANCE INFORMATION

PRIMARY

NAME OF INSURED

☐Mr ☐Ms ☐Miss ☐Mrs ☐Dr

☐X

Last First First Middle

Birth Date:

ADDRESS

Street City Prov Postal Code

Employer Name

ADDRESS

Street City Prov Postal Code

Insurance Plan Name and Address:

Insurance ID# Group #

SECONDARY

NAME OF INSURED

Last First Middle

Birth Date:

ADDRESS

Street City Prov Postal Code

Employer Name

ADDRESS

Street City Prov Postal Code

Patient's relationship to insured:

☐Self ☐Spouse ☐ Child ☐ Other

Insurance Plan Name and Address

ID# Group #

CONSENT FOR SERVICES (insured/non insured)

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I authorize release; to my dental benefits plan administrator and CDA, information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revoked the same.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient/parent/guardian	Date:	Relationship to Patient

Signature of patient/parent/guardian	Date:	Relationship to Patient

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RESCHEDULING POLICY

WE TRY OUR VERY BEST TO OFFER YOU APPOINTMENTS THAT ACCOMMODATE YOUR SCHEDULES. THIS TIME IS RESERVED JUST FOR YOU. IN ORDER TO GIVE YOU THE BEST CARE POSSIBLE AND TO BE FAIR TO ALL OUR PATIENTS, WE ASK THAT YOU MAKE EVERY EFFORT TO KEEP THESE APPOINTMENTS.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, WE ASK THAT YOU GIVE US AT LEAST TWO BUSINESS DAYS NOTIFICATION.

FAILURE TO NOTIFY US MAY RESULT IN A RESCHEDULING FEE OF $50.00 OR GREATER. THIS FEE MUST BE PAID PRIOR TO STARTING ANY FURTHER TREATMENT.

THANK YOU FOR YOUR COOPERATION.

_____ _____

SIGNATURE DATE

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FINANCIAL AGREEMENT

PAYMENT ARRANGEMENTS FOR ALL DENTAL WORK ARE TO BE MADE AT THE TIME OF YOUR DENTAL TREATMENT. WE DO NOT ACCEPT PAYMENT FROM THE INSURANCE COMPANIES.

WE OFFER THE FOLLOWING PAYMENT OPTIONS:

- VISA
- MATERCARD
- INTERAC
- CASH

KEEP IN MIND, IF YOU HAVE DENTAL INSURANCE AND OUR OFFICE CAN SUBMIT YOUR CLAIM ELECTRONICALLY, YOU SHOULD RECEIVE YOUR CHEQUE FROM INSURANCE COMPANY WITHIN 2-7 DAYS.

FINANCING OPTIONS ARE AVAILABLE FOR ALL TREATMENTS: PLEASE ASK ANY OF OUR TEAM MEMBERS TO ASSIST WITH MAKING ARRANGEMENTS.

***PLEASE NOTE WE DO NOT ACCEPT PERSONAL CHEQUES

_____ _____

SIGNATURE DATE

OFFICE POLICY FOR THE COLLECTION, USE AND DISCLOSURE OF PATIENT PERSONAL INFORMATION

As dental professionals we are required to comply with Federal and Provincial Privacy Legislation, (PIPEDA) and (PHIPA). In order to do so, each of our patients are requested to sign a consent form acknowledging and allowing us to collect, use and disclose personal information according to specific guidelines.

OFFICE POLICY FOR THE COLLECTION, USE AND DISCLOSURE OF PATIENT PERSONAL INFORMATION

Privacy of your personal information is an important part of providing you with quality dental care. We understand the importance of protecting your privacy, and we are committed to collecting, using and disclosing your personal information responsibly.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Our office has a Privacy Code, which you may review at any time, and freely discuss with our Privacy Information Officer (federal) also known as our Health Information Custodian (provincial). In our office we will collect, use and disclose information about you for the following purposes:

- to assess your health needs and risks, and to provide safe and efficient dental care
- to enable us to contact you, to schedule and confirm appointments, including following up for treatment
- to offer and to provide treatment, care and services in relationship to the mouth and jaws and dental care generally to communicate with other treating health-care providers, including other specialists and general dentists, and/or referring dentists, physicians, pharmacists, and laboratory technicians
- to allow us to efficiently manage your account, including invoicing for goods and services, obtaining debit and credit card payments, credit authorization purposes, and for collection of unpaid accounts
- to complete and prepare dental treatment estimates/claims for third party adjudication to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- to permit potential purchasers, practice brokers or legal and financial advisors to evaluate the dental practice
- to provide your information and records to the dentist's insurance carrier if required
- for teaching and demonstrating purposes on an anonymous basis

- to assist this office to comply with all regulatory requirements and comply generally with the law.

Patient Acknowledgement and Consent

I have reviewed the above information that explains why and how your office will collect, use and disclose my/my child's personal information, and have been given the opportunity to ask questions about the steps your office is taking to protect this information.

I acknowledge and agree that the office of

Dr. _____

can collect, use and disclose personal information about me /my child for the purposes listed.

_____	_____	_____
Patient	Patient Signature	Date
_____	_____	_____
Witness	Witness Signature	Date