STONY PLAIN
DENTAL CENTRE

3919 49th Avenue Suite 109
Stony Plain, Alberta T7Z 1V5
Phone: 780-963-4626
Fax: 780-963-0195
www.stonyplaindental.com
admin@stonyplaindental.com

CONFIDENTIAL PATIENT INFORMATION AND HEALTH HISTORY - CHILD

TODAYS DATE: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____ Weight: _____ Height: _____

preferred pronouns _____

Mailing Address: _____ City/Town: _____

Postal Code: _____ Primary Guardian Email: _____

Primary Guardian: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____

Secondary Guardian: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____

Family Physician/Pediatrician: _____ Phone: _____

Child's Former Dentist: _____

Name of Personal Responsible for this Account/Card Holder: _____

REFERRAL INFORMATION

How did you hear about us?

☐ Tradeshow ☐ Community BBQ ☐ Google ☐ Facebook ☐ Instagram
☐ Farmer's Day Parade ☐ Movie Theatre ☐ Website ☐ Location ☐ Clinic/Patient Referral

*Please fillout the line below

Name of person or office referring you to our practice: _____

☐ Other, please explain: _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY
Employer: _____
Business Address: _____
Phone: _____
Insurance Co.: _____
Policyholder Name: _____
Policyholder DOB: _____
Policy/Group No.: _____
ID Number: _____

SECONDARY DENTAL INSURANCE COMPANY
Employer: _____
Business Address: _____
Phone: _____
Insurance Co.: _____
Policyholder Name: _____
Policyholder DOB: _____
Policy/Group No.: _____
ID Number: _____

CHILDS HISTORY

School Currently Attending: _____ Grade Enrolled In: _____

Hobbies/Sports: _____

Brothers' & Sisters' Names and Ages: _____

Favourite Toy: _____ Favourite Person: _____

Are you seeking treatment for any particular reasons and/or routine dental care?

_____

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MEDICAL HISTORY INFORMATION

Have you ever had or have any of the following? Please check those that apply:

☐ AIDS	☐ Allergies	☐ Anemia	☐ Tonsils Removed
☐ Measles	☐ Abnormal Blood Pressure	☐ Asthma	☐ Tuberculosis
☐ Mumps	☐ Ear Trouble	☐ Cancer	☐ Adenoids Removed
☐ Diabetes	☐ Dizziness	☐ Epilepsy	☐ Broken Bones
☐ Fainting	☐ Chest Pains	☐ Lung Disease	☐ Growths
☐ Hard to Freeze	☐ Hay Fever	☐ Head Aches	☐ Head Injuries
☐ Heart Trouble	☐ Hearing Aids	☐ Hepatitis	☐ HIV +
☐ Hives	☐ Operations	☐ Jaundice	☐ Kidney Disease
☐ Strep Throat	☐ Ankle Swelling	☐ Skin Rash	☐ Physical Deformity
☐ Chicken Pox	☐ Nervous Disorders	☐ Gland Trouble	☐ Stomach Problems
☐ Scarlet Fever	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Other		

If yes to any of the above, please describe: _____

_____

When did your child last visit the Physician/Pediatrician? _____

Reason: _____

Has your child ever had any serious illness or been hospitalized? _____

If so, please describe: _____

Does your child have any known medical, physical or mental handicaps? _____

If so, please describe: _____

Is your child allergic to anything? _____

Does he/she bruise easily or bleed excessively? _____

Does your child have any blood disease? _____

Is your child now taking, or has he/she had:

☐ Penicillin	☐ Other Antibiotics	☐ Cortisone
☐ Local Anesthesia	☐ General Anesthesia	☐ Other Drugs

Has he/she ever had any unfavourable reaction to any drug? _____

Is there a history or any inherited diseases in the family? _____

If yes, please describe: _____

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CONFIDENTIAL PATIENT INFORMATION AND HEALTH HISTORY - CHILD

DENTAL HISTORY

Is there a family history of:

☐ High Decay Rate ☐ Tooth Deformity ☐ Extra Teeth ☐ Cleft Lip/Palate

☐ Missing Teeth ☐ Spaced Teeth ☐ Crooked Teeth ☐ Gum Disease

If yes, please describe: _____

Does your child have any oral habits such as:

☐ Thumb-sucking ☐ Lip Biting ☐ Mouth Breathing ☐ Chewing (e.g.pencils)

☐ Finger-sucking ☐ Nail Biting ☐ Teeth Grinding ☐ Tongue Thrusting

If yes, please describe: _____

Has your child ever had an accident, injury or surgery about the mouth? _____

If yes, please describe: _____

Has your child ever had an unpleasant experience associated with dental treatment? _____

If yes, please describe: _____

Has your child ever had orthodontic treatment? ☐ Yes ☐ No

How often does your child brush his/her teeth? _____

Do you supervise the child while toothbrushing? ☐ Yes ☐ No

Has your child ever received fluoride supplements in the diet or water supply? ☐ Yes ☐ No

Were his/her teeth ever treated with decay-preventing topical fluorides? ☐ Yes ☐ No

Have you ever received a dental consultation on your children's diet? ☐ Yes ☐ No

Are you interested in a caries (dental decay) preventive program for your child? ☐ Yes ☐ No

ADDITIONAL INFORMATION

If there is any specific problem regarding your child's oral health which concerns you, or if there is any additional information which you feel may be helpful in our care of your child, please describe below :

_____

_____

Terms and conditions (Continued and sign on following page)

Appointments:
Please help us maintain the operation of our office on sound principle so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore we will need at least 48 HOURS NOTICE to be given if cancellation is necessary. No show or last minute cancellations can result in a $100 cancellation fee.

Payment of Fees:
This office is willing to accept direct payment from your dental plan for services which your plan covers. If your dental plan does not cover the full cost of your treatment, you will be responsible for any difference between the amount paid by your plan and the amount charged. Your portion is then due and payable on the day of your appointment. You are responsible for providing necessary information in order for us to direct bill your insurance company as well as informing us of any changes in this information.

General Release:
I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history, and have not knowingly omitted any information. I also authorize the communication of information related to the coverage of serviced described in this form to the named doctor.

Consent:
I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated and consent to the use of local anesthetic agents. I understand the above statements regarding payment of fees and accept the responsibility for payment for dental services provided by myself or my dependents, due and payable when services are rendered unless other financial arrangements have been made.

<u>Personal Information Consent</u>
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 summarized 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, addresses, phone numbers, and email addresses. (Collectively referred to as "Contact Information"). Contacted 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
- 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 out 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 purposed 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 us 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 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

Dentists in Alberta 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 have read the above, and I consent to the collection, use, and disclosure of my personal information as set out above.

Signature: _____ Date: _____

✔ I accept this as my electronic signature for the purpose of this form

Relationship to Patient (f Patient is under 18 years of age): _____

Stony Plain Dental Centre - Understanding your Insurance Coverage and Payment Options

If you do not have insurance

If you do not have insurance, you are responsible to pay the full cost of your dental treatment following your appointment. At Stony Plain Dental Centre, we offer a financing option, HealthSmart, that may be an option for you.

Financing option: PayBright

PayBright is a financing option starting at 0% interest. You are able to apply within the office with your drivers license. Please ask the front desk if you are interested in this option, they can give you more information, explain the process and requirements, and get you set up.

If you have insurance

Welcome to Stony Plain Dental Centre. Our office is pleased to offer assistance in submitting your dental claims. We can do this in one of two ways, assignment or non-assignment.

Non-Assignment - Non-Assignment means you are responsible for paying the cost of your dental treatment after each appointment. We are happy to process the all of the paperwork for you, normally electronically, and submit it directly to your insurance company. The insurance company will then pay you back directly, some within 24 to 48 hours. This option is beneficial as it allows you to keep track of your yearly maximum.

Assignment - Assignment means our office will bill directly to your insurance company. With this option, you are responsible to pay any remaining balance (any amount that your insurance plan does not cover). You are also responsible for knowing what your yearly maximum is and what is remaining on it. Most major insurance companies have a free app for your phone that allows you to keep track of your yearly maximum. We do not have access to this information as it is private information between you and your insurance compnay.

Insurance plans typically do not pay 100% - You are required to pay the difference.

Your dental insurance plan may not match(pay) all dental fees. Therefore, there is an amount remaining that you are responsible to pay immediately after the insurance payment is recieved. We ensure your fees are competitive with the area and also reflect the quality of service our staff and dentists provide.

At Stony Plain Dental Centre, we will accept all insurance plans, provided they will make payment directly to the dentist. We work with the majority of insurance plans and are willing to send pre-authorizations for further treatment when requested by you. Please remember these preauthorizations are only estimates, as treatment may change acoording to the needs of the patient. Please also be advised that most insurance companies will only give a payment estimate directly to the policy holder; therefore, we may not be able to obtain this information for you.

I have read and understand Stony Plain Dental Centre's Policy for payment requirements and for billing my insurance company.

Patient (or parent if under 18) Signature: _____ **Date:** _____

✔ I accept this as my electronic signature for the purpose of this form

Patient Insurance Information

Because of privacy, your insurance does not give us the following information. Please complete the the known information about your insurance policy.

Yearly Max: _____ ☐ Unlimited

Year End: _____ (i.e., December 31)

% Coverage: _____ ☐ 80% ☐ 100%

How much is used to date: _____ Date: _____

Major Coverage: _____ ☐ Unlimited

% Coverage for Major: _____ ☐ 50% ☐ 80% ☐ 100%

How much Major used to date: _____

I am covered for:

New Patient Exam ☐ Yes ☐ No If no, when is next new patient exam? _____

Panoramic X-ray ☐ Yes ☐ No If no, when is next panoramic x-ray? _____

Crowns ☐ Yes ☐ No If yes, how much coverage? _____

Units of scaling per year: _____ Units ☐ Unlimited

I understand that any unpaid balance is my responsibility to pay.

I understnad the financial policy of Stony Plain Dental Centre and that I will be presented a receipt for all transactions processed.

I have read and understand all information regarding Stony Plain Dental Centre's financial policy information, and certify, to my knowledge, that the information I have provided is accurate.

Patient (or parent if under 18) Signature: _____ Date: _____

✔ I accept this as my electronic signature for the purpose of this form

Parent Guidelines

Dear Parents,

Thank you for choosing to bring your child to Stony Plain Dental Centre!
At our office, you may choose whether you want to accompany your child during their appointment. We know that some children do better without a parent present, but we are open to having you with your child.
If you choose to be present during the appointment, we suggest the following. Please:

- Allow us to prepare your child
- Be supportive of our practice's terminology
- Be a silent observer

If you are a silent observer, we are better able to communicate with your child. Children normally listen to their parents and may not hear our guidance if you are speaking.
We encourage you to support your child with touches.
If you are asked to leave, please be ready to immediately walk away. Many children will try to become involved if we ask you to leave. By leaving immediately, we can prevent your child from trying to control the situation. After you leave, we will continue to support your child.
These are important ways you can help with the success of your child's visit. We are confident all will go well in the appointment, and we hope these guidelines will help you prepare for the appointment. Please let us know if you have any questions.

Practice Terminology

To improve the chances your child has a positive experience in our office, we are selective in our use of words. We try to avoid words that scare or frighten children. Please support us by not using negative words often used in dental care. These words include, but are not limited to:

Don't Use	Use
Needle or shot	Sleepy juice
Drill	Whistle
Drill on tooth	Clean a tooth
Pull or yank	Wiggle a tooth out
Decay or cavity	Sugar bug
Examination	Count teeth
Tooth cleaning	Tickle teeth
Explorer	Toothpick
Rubber dam	Raincoat
Gas	Magic air

Using these words will help you understand your child's description of their dental experience. Our intention is not to "fool" the child; it is to create an experience that is positive.
We appreciate your cooperation in helping us make your child comfortable in our office.

Sincerely,
Stony Plain Dental Centre

_____ _____

Parent Name Parent Signature

✔ I accept this as my electronic signature for the purpose of this form