CHILD PATIENT INFORMATION FORM

Welcome to our office!

Please assist us by completing the following questions: EXAM DATE: .....20.....

CHILD'S NAME .....
GENDER.....
FIRST INITIAL LAST
DATE OF BIRTH..... AGE.....
ADDRESS.....
.....
POSTAL CODE..... HOME PHONE #..... CHILD CELL#.....
SCHOOL .....GRADE .....
LIST SPORTS, HOBBIES, AND INTERESTS:
.....
CHILD'S DENTIST..... PHYSICIAN
.....
WHO MAY WE THANK FOR REFERRING YOU TO US / WHAT MADE YOU CHOOSE US? .....
.....
.....

FATHER'S NAME.....
EMAIL.....
CELL#.....BUSINESS PHONE#.....
ADDRESS/PHONE# SAME AS ABOVE ☐
or.....

MOTHER'S NAME.....
EMAIL.....
CELL#.....BUSINESS PHONE#.....
ADDRESS/PHONE# SAME AS ABOVE ☐
or.....
PARENT'S MARITAL STATUS: SINGLE ☐ MARRIED ☐ OTHER ☐
CHILD LIVES WITH: BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER ☐
NUMBER OF CHILDREN IN FAMILY..... AGE AND SEX

PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT?
.....
IF YOU WOULD **NOT** LIKE TO BE CONTACTED BY TEXT FOR APPOINTMENT REMINDERS, PLEASE CHECK HERE ☐

DO YOU HAVE DENTAL INSURANCE THAT COVERS **ORTHODONTIC** TREATMENT? YES ☐ NO ☐
PRIMARY INSURANCE
POLICY HOLDERS NAME..... DATE OF BIRTH.....

INSURANCE COMPANY ..... GROUP #
.....ID#.....
EMPLOYER/OCCUPATION
.....
ORTHODONTIC LIFETIME MAXIMUM..... PERCENTAGE
COVERED.....
HAVE YOU USED ANY OF THESE BENEFITS PREVIOUSLY?
.....

SECONDARY INSURANCE
POLICY HOLDERS NAME..... DATE OF BIRTH
..... INSURANCE COMPANY
..... GROUP # .....ID# .....
EMPLOYER/OCCUPATION
.....
ORTHODONTIC LIFETIME MAXIMUM..... PERCENTAGE
COVERED.....
HAVE YOU USED ANY OF THESE BENEFITS PREVIOUSLY?
.....

Please note: Our office charges the patient/parent directly for all services rendered. However, we will be happy to assist you with your dental claim form if required.

MEDICAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THE PATIENT HAS OR HAD IN THE PAST:

Diabetes	☐	Arthritis	☐	Gland Problems	☐
Pneumonia	☐	Anemia	☐	Prolonged Bleeding	☐
Heart Trouble	☐	Epilepsy	☐	Liver Involvement	☐
Rheumatic Fever	☐	Asthma	☐	Fainting & Dizziness	☐
Bone Disorders	☐	Kidney Involvement	☐	Nervous Disorder	☐
Aids	☐	Hepatitis	☐	Growth Disorder	☐

	YES/NO
IS THE CHILD IN GOOD HEALTH?	☐ ☐
IS THE CHILD UNDER PHYSICIANS CARE NOW?	☐ ☐
DOES THE CHILD HAVE ANY HISTORY OF MAJOR ILLNESS OR OPERATIONS?	☐ ☐
LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN - GIVE REASONS	☐ ☐

LIST ANY **ALLERGIES** OR DRUG SENSITIVITY
DOES CHILD HAVE TENDENCY TO: COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____	☐ ☐
HAS CHILD REACHED PUBERTY? GIRLS – HAS SHE STARTED MENSTRUATION	☐ ☐
BOYS – HAS HIS VOICE CHANGED	☐ ☐
IS THERE ANY HISTORY OF BIRTH OR DEVELOPMENTAL DEFECTS?	☐ ☐

CHILD'S HEIGHT ..... PARENT'S HEIGHT – MOTHER ..... FATHER
.....

DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? IF SO, DESCRIBE ☐ ☐
HAS THE CHILD EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE? ☐ ☐
DOES THE CHILD HAVE SPEECH PROBLEMS? ☐ ☐
IS THE CHILD A MOUTH BREATHER WHILE AWAKE? YES ☐ NO ☐ UNKNOWN ☐ WHILE ASLEEP? ☐ ☐
ARE THERE ANY MISSING OR EXTRA PERMANENT TEETH? ☐ ☐
HAS CHILD HAD ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR EARS? ☐ ☐
WHEN DID THE CHILD LAST HAVE DENTAL CARE?
IS THERE ANY DENTAL WORK STILL TO BE DONE? ☐ ☐
DOES THE CHILD GRIND OR CLENCH HIS/HER TEETH? ☐ ☐
HAS THE CHILD'S TEETH ERUPTED: EARLY ☐ AVERAGE ☐ LATE ☐
HAS EITHER PARENT OR OTHER CHILDREN HAD ORTHODONTIC TREATMENT? ☐ ☐
IS THERE ANOTHER FAMILY MEMBER WITH SIMILAR ORTHODONTIC PROBLEMS? ☐ ☐
HAS THE CHILD HAD PREVIOUS ORTHODONTIC EXAMINATIONS? ☐ ☐
DOES THE CHILD WANT ORTHODONTIC TREATMENT? ☐ ☐

WHAT IS YOUR MAIN ORTHODONTIC CONCERN?

WHAT WOULD BE IMPORTANT CONSIDERATIONS FOR TYPE OF ORTHODONTIC TREATMENT?

☐ INVISIBLE (ESTHETICS) ☐ FASTER TREATMENT TIME

☐ COMFORT AND FUNCTION OF BRACES/APPLIANCES ☐ USE OF LATEST TECHNOLOGY

IS THERE ANYTHING WE SHOULD BE AWARE OF TO HELP US PROVIDE OPTIMUM CARE FOR YOUR CHILD?

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I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I give my consent for Dr. Popowich and staff to perform a clinical examination and take diagnostic records/information.

Parent/ Guardian's Name _____Signature _____

Dental Office Personal Information Consent Form

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 e-mail addresses (collectively referred to as "Contact information"). Contact Information is collected and used for the following purposes:

- To open and update patient files.
- To invoices 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 our patients about their health history, their family health history, physical condition, and dental treatments (collectively referred to as "Medical Information"). Patient's Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.
Patient's 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 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.

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

PatientName_____Parent/Guardian_____

Date_____ Signature_____