avenue
PEDIATRIC DENTISTRY

About Your Child

_____
Child's Name

_____
Age Gender Date of Birth

_____
Address Unit Number

_____
City Province Postal Code

_____
Home Phone Alberta Healthcare Number

_____
Who may we thank for this referral?

Parents' Marital Status:
□ Married □ Separated □ Divorced □ Widowed
□ Single

Dental History

Is this your child's first visit to the dentist?
□ Yes □ No
If no, when was the last visit and what was done at this time? _____
_____

Please describe any concerns you have about your child's teeth or oral health. _____
_____
_____

Do you expect your child to be a cooperative patient?
□ Yes □ No
If no, please explain. _____
_____

Has your child bumped or broken any teeth?
□ Yes □ No
If so, when? _____
_____

Does your child use a bottle, sippy-cup or breastfeed?
□ Yes □ No
How often does your child brush? _____
Is tooth-brushing supervised?
□ Yes □ No
By whom? _____
Does your child use fluoride toothpaste?
□ Yes □ No □ Not Sure
Does your child floss?
□ Yes □ No
Does your child have or has she/he had any of the following problems or habits?
□Thumb Sucking *How Long?* ____ *Still Active?* ____
□ Pacifier *How Long?* ____ *Still Active?* ____
□ Nail Biting *How Long?* ____ *Still Active?* ____

Medical History

Who is your child's family doctor or pediatrician?
Physician's Name: _____
Address: _____
Phone Number: _____
Is your child in good health?
□ Yes □ No
If no, please explain. _____
_____

Is your child under the care of a physician for anything other than routine checkups?
□ Yes □ No
If yes, please explain. _____
_____

Does your child take medication (including natural remedies or vitamins)?
□ Yes □ No
If yes, please list. _____
_____

Does your child have any allergies?
□ Yes □ No
If yes, please explain. _____
_____

Are your child`s vaccinations up-to-date?
□ Yes □ No □ No Vaccinations
Has your child ever been hospitalized or had surgery?
□ Yes □ No
If yes, please explain. _____
_____

Please indicate if your child has/had any of the following:

□ Anemia	□ Gastric Disease or Reflux
□ Arthritis	□ Heart Disease
□ Asthma	□ HIV
□ Autism/Asperger's	□ Hyperactivity/ADD/ADHD
□ Autoimmune Disorder	□ Intellectual Disability
□ Bleeding Disorder	□ Kidney Disease
□ Bone Disorder	□ Latex Sensitivity
□ Cancer	□ Liver Disease or Hepatitis
□ Cerebral Palsy	□ Physical Disability
□ Cleft Lip or Palate	□ Radiation Treatment
□ Diabetes	□ Rheumatic Fever
□ Down Syndrome	□ Speech Problems
□ Endocrine Disorder	□ Tourette Syndrome
□ Epilepsy/Seizure Disorder	□ Tuberculosis

If your child has a condition affecting his/her heart, did the physician advise taking antibiotics before dental treatment?
□ Yes □ No □ Not Applicable
Please comment on any items that were checked in the above list. _____
_____
_____
_____
_____
_____

If needed, please do not hesitate to ask one of our receptionists for assistance when completing this form.

avenue
PEDIATRIC DENTISTRY

Responsible Parties

Parent One:

Full Name

Address | Unit Number

City | Province | Postal Code

Date of Birth | Home Phone

Cell Phone | Business Phone

Occupation | Email Address

Dental Insurance:
□ Yes □ No

Insurance Provider | Phone Number

Group/Policy Number | ID/Certificate

Parent Two:

Full Name

Address | Unit Number

City | Province | Postal Code

Date of Birth | Home Phone

Cell Phone | Business Phone

Occupation | Email Address

Dental Insurance:
□ Yes □ No

Insurance Provider | Phone Number

Group/Policy Number | ID/Certificate

Emergency Contact

Name | Relationship

Home Phone | Cell Phone

Financial Policies

Payment is expected at the time of treatment.

As a courtesy to you, our office will complete the dental portion of the insurance claim form and submit to your provider for reimbursement. To expedite processing, please ensure that you provide our office with any changes in insurance coverage, address and/or phone number(s).

Please be advised that dental insurance or benefits are a contract between you, your employer and your insurance company. Under provincial legislation, the majority of insurance providers will not supply our office with any details concerning your coverage. We cannot influence the coverage provided by your plan. Your insurance benefits are determined by your individual policy and carrier. We do not know if your insurance provider will cover the prescribed treatment; nevertheless, you can review the policy handbook supplied to you by your employer. If you are utilizing government assistance (e.g., Alberta Works), you are responsible for any charges not covered by your plan.

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

If you require a predetermination prior to treatment, we will provide a treatment plan for review by the third party payer; however, please remember that you are still responsible for paying this office for treatment provided. The third party payer is responsible to you. Predeterminations may take up to six weeks to process.

Please indicate your method(s) of payment:
□ Cash
□ Debit
□ Visa
□ Mastercard
□ Government Insurance (e.g., Alberta Works, NIHB)

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

Parent/Legal Guardian Name

Parent/Legal Guardian Signature

Witness Name

Witness Signature

Date

If needed, please do not hesitate to ask one of our receptionists for assistance when completing this form.

avenue
PEDIATRIC DENTISTRY

Confirming Appointments

For your convenience, we will contact you prior to your child's scheduled appointment to confirm the date and time. In consideration to our staff and other families, **we request at least two (2) business days notice prior to cancelling or rescheduling an appointment**. More than two (2) missed appointments may result in a rebooking fee.

Please indicate the best method for confirming your child's dental appointments:

□ Phone Call
□ Text Message
□ Email

Consent for Dental Treatment

As the parent and/or legal guardian of my child, I give my consent to Dr. D. Perusini and associates to examine clean and provide any necessary dental treatment to my child.

I understand that examination may involve taking dental x-rays, and I authorize Dr. D. Perusini and his staff to do so.

I accept and understand the specific policies provided to me concerning parental presence in the dental operatory.

I understand that I will meet with the dentist to review my child's treatment needs prior to scheduling any prescribed treatment.

I UNDERSTAND AND ACCEPT THE ABOVE TERMS.

_____
Parent/Legal Guardian Name

_____
Parent/Legal Guardian Signature

_____
Dentist Signature

_____
Date

If needed, please do not hesitate to ask one of our receptionists for assistance when completing this form.

avenue
PEDIATRIC DENTISTRY

Privacy Policies

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 form 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,
* To send patients information 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, family history, physical condition, and prior dental care (collectively referred to as *medical information*). Patients' medical information is collected and used for the purpose of diagnosing dental conditions and providing safe 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 the family physician, pediatrician or other specialist for the purpose of medical consultation prior to dental treatment;
* To other dentists and/or dental specialists when we are seeking a second opinion, and the patient has consented to proceed with a said referral; and,
* To other dentists and/or dental specialists if the patient, with appropriate consent, has been referred by us to another dentist and/or dental specialist for treatment.

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 UNDERSTAND THE ABOVE TERMS, AND PERMIT DR. D. PERUSINI AND ASSOCIATES TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION CONCERNING MYSELF AND MY CHILD, _____.

_____
Parent/Legal Guardian Name

_____
Parent/Legal Guardian Signature

_____
Witness Signature

_____
Witness Signature

_____
Date

If needed, please do not hesitate to ask one of our receptionists for assistance when completing this form.