



560 First Edmonton Place
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t 780.428.7761
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New Patient Intake

If communicating in English is a challenge, please bring an interpreter to assist you.

About Your Child

Child's Name _____ DOB (DD/MM/YYYY) _____

Gender at birth: Male Female Patient identifies as: Male Female Non Binary

Alberta Healthcare Number _____

Responsible Parties

Parent/Guardian One

Full Name _____

Date of Birth _____

Address _____ Unit # _____

City _____ Province _____

Postal Code _____

Cell Phone _____ Home Phone _____

Email Address _____

Dental Insurance: Yes No

Employer _____

Insurance Provider _____

Group/Policy Number _____

ID/Certificate _____

Parent/Guardian Two

Full Name _____

Date of Birth _____

Address _____ Unit # _____

City _____ Province _____

Postal Code _____

Cell Phone _____ Home Phone _____

Email Address _____

Dental Insurance: Yes No

Employer _____

Insurance Provider _____

Group/Policy Number _____

ID/Certificate _____

Patient resides with: Both parents Parent/Guardian **one** Parent/Guardian **two** Other _____

Who may we thank for this referral? Professional (Dentist, Doctor, etc.) Internet Family/Friend
 Other _____

Emergency Contact

Name _____ Relationship _____

Home Phone _____ Cell Phone _____



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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?

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 yes, when? _____

Does your child use a bottle, sippy-cup or breastfeed? Yes No

How often does your child brush? _____ Is 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?

- | | | |
|--|-----------------|--|
| <input type="checkbox"/> Thumb Sucking | How Long? _____ | Still Active? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pacifier | How Long? _____ | Still Active? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Nail Biting | How Long? _____ | Still Active? <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

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

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Trauma | <input type="checkbox"/> Toothache | <input type="checkbox"/> Gum infections |
| <input type="checkbox"/> Jaw sounds | <input type="checkbox"/> Sensitive teeth | <input type="checkbox"/> Colored teeth | <input type="checkbox"/> Grinding of teeth |
| <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Other: _____ | | |

Comments: _____

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 _____

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



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Medical History Continued

Has your child ever been hospitalized, had surgery or had general anaesthesia? Yes No

If yes, please explain _____

Is your child under the care of a physician for anything other than routine checkups? Yes No

If yes, please explain _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Autism/Asperger's | <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Cleft Lip or Palate | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Endocrine Disorder | <input type="checkbox"/> Epilepsy/Seizure Disorder | <input type="checkbox"/> Gastric Disease or Reflux |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV | <input type="checkbox"/> Hyperactivity/ADHD |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Latex Sensitivity |
| <input type="checkbox"/> Liver Disease or Hepatitis | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Tourettes Syndrome |
| <input type="checkbox"/> 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 or any other conditions that were not listed.



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Confirming/Cancelling Appointments

Our office 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 your appointment.**

If less than 2 business days notice is given to cancel or reschedule an appointment or no notice is given and the patient does not show up for their scheduled appointment, a re-booking fee of \$100.00 may result.

In the event a patient does not “show up” on a second occasion, our office policy is to ask the patient to find a different practice, at which point our administrative staff will be happy to transfer the records of that patient to a new office.

Please indicate the best method for confirming your child’s dental appointments: Phone Call Text Message Email

I have read and understand the above terms _____ (Initial)

Consent for Dental Treatment

As the parent and/or legal guardian of my child, I give my consent to Dr. 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. Perusini and his staff to do so.
- I understand that I will meet with the dentist to review my child’s treatment needs prior to scheduling any prescribed treatment.

I have read and understand the above terms _____ (Initial)

Payment and Insurance Policy

Private Insurance

Payment will be collected at the time of service *and* your insurance provider will reimburse you directly in accordance with your insurance plan.

Government Support

If you have coverage with one of the Government provided plans such as Alberta Child Health Benefits, Alberta Social Services or Non-insured Health Benefit, you must provide the client number to the office prior to any treatment so coverage can be verified. This benefit plan will cover the cost of treatment, however, please be aware that in the event your coverage is not in effect, you will be responsible to pay for any treatment provided.

Canadian Dental Care Plan

In accordance with the plan as outlined by the Government of Canada, our office will direct bill the policy and you will be responsible to pay the co-pay at the time of treatment if applicable.

I have read and understand the above, and agree to assume full liability for fees _____ (Initial)



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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 College of Dental Surgeons of Alberta, 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. Perusini and associates to collect, use and disclose personal information concerning myself and my child _____ (initial)

Patient Acknowledgement

By my signature, I acknowledge that I have read, understand, and agree to **ALL** the policies and procedures as defined on pages 4 & 5.

Parent/Legal Guardian Name

Parent/Legal Guardian Signature

Dentist Signature

Date