



## CHILD INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide your dental services.

### ABOUT YOUR CHILD

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ D/M/Y Sex: \_\_\_\_\_ Age: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ -Prov: \_\_\_\_\_ PC: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 WHOM MAY WE THANK FOR YOUR REFERRAL: \_\_\_\_\_ School: \_\_\_\_\_

### MOTHER'S/FATHER'S INFORMATION

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
 Mother's Employer: \_\_\_\_\_ Father's Employer: \_\_\_\_\_  
 Mother's Mobile Phone: \_\_\_\_\_ Father's Mobile Phone: \_\_\_\_\_

### PRIMARY DENTAL INSURANCE

Company Name: \_\_\_\_\_  
 Subscribers/Policy Holders Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Day/Month/Year  
 Group # \_\_\_\_\_ ID or CERT # \_\_\_\_\_  
 Basic % of Coverage \_\_\_\_\_ Major % \_\_\_\_\_ Maximum Per Year \_\_\_\_\_  
 What restrictions do you have on your dental plan? \_\_\_\_\_  
 (ie. How often is polishing covered? Is fluoride covered? How many units of scaling are covered?)

### SECONDARY DENTAL INSURANCE

Company Name: \_\_\_\_\_  
 Subscribers/Policy Holders Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Day/Month/Year  
 Group # \_\_\_\_\_ ID or CERT # \_\_\_\_\_  
 Basic % of Coverage \_\_\_\_\_ Major % \_\_\_\_\_ Maximum Per Year \_\_\_\_\_  
 What restrictions do you have on your dental plan? \_\_\_\_\_  
 (ie. How often is polishing covered? Is fluoride covered? How many units of scaling are covered?)

### INSURANCE

Direct Billing is a courtesy we offer to our patients and in order to 'Direct Bill' your insurance provider, we require a credit card on file for any outstanding amounts owing after your insurance provider has paid their portion. Outstanding accounts over 60 days will be charged 2% interest monthly. I hereby agree to the Financial Policy of Prograce Dental as outlined above and authorize Prograce Dental to apply any outstanding balance on my account, not covered by my insurance provider, to the credit card listed below:

#### Payment Options are as Follows:

**VISA**

**Master Card**

Card #: \_\_\_\_\_ Expiry Date: \_\_\_\_\_ CC Security Code: \_\_\_\_\_  
 Card Holder's Name as appears on card: \_\_\_\_\_ Authorized Signature: \_\_\_\_\_

## MEDICAL HEALTH HISTORY

Name of your child's Physician: \_\_\_\_\_

**DOES YOUR CHILD HAVE OR EVER HAD?** Please check yes or no:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS/A.R.C.
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Handicaps/Disabilities
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic or Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis

**HAS YOUR CHILD EVER HAD AN ALLERGIC REACTION TO THE FOLLOWING?** Please check yes or no:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetic (Freezing)
<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other Antibiotics
<input type="checkbox"/>	<input type="checkbox"/>	Codeine, Demerol or other narcotics
<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Latex

Please list any current medications, vitamins or supplements.

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## DENTAL HISTORY

Please check yes or no to the following questions.

Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Does your child have any dental problems?	If Yes, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Has your child been to the dentist before?	If yes, date of last visit: _____
<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever had a serious/difficult problem associated with dental work?	If yes, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Does your child have a finger or thumb habit?	If yes, how long: _____
<input type="checkbox"/>	<input type="checkbox"/>	Has your child ever had an injury to the face or jaw?	If yes, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you happy with the appearance of your child's teeth?	If no, please explain: _____

How often does your child brush? \_\_\_\_\_ How often does your child floss? \_\_\_\_\_

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

# Dental Office Personal Information Consent Form

## Personal Information & Protection Act

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 summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances 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 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 materials.
- To follow up with treatment and/or customer service.

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".) Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed for the following purposes:

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 healthcare professionals, such as physicians, if the patient, with their consent, has been referred by us to the other healthcare 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.

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Patient/Guardian Name

Signature

Date