SIERRA SPRINGS DENTAL

Medical History

Childs Name: _____

Address _____ City _____ Postal Code _____

Phone # (Home) _____ (Cell) _____ Sex M☐ F☐ Birth Date _____ /_____ /_____
Day Month Year

Email _____ Mother's Name _____

Emergency Contact Name _____ Employer _____ Phone (Cell) _____

Emergency Contact Number _____ Father's Name _____

Person Responsible for account _____ Employer _____ Phone (Cell) _____

WHOM MAY WE THANK FOR YOUR REFERRAL: Friend☐ Name _____

Google☐ Yellow Pages☐ Newspaper☐ Flyer☐ Website☐ Other☐ Please specify _____

How would you like appointment reminders? Phone ☐ Text ☐ Email ☐

1. **Have you been under the care of a medical doctor during the past two years?** Yes☐ No☐

   If yes, for what? _____

   Physician's Name _____ Phone # _____

2. **Please list any current medications, vitamins, or supplements:** _____

   _____

   _____

3. **Are you aware of having an allergic (or adverse) reaction to any medication or substance?** Yes☐ No☐

   If yes, please list _____

4. **Has your child been hospitalized in the past five years?** Yes☐ No ☐

5. **Indicate which of the following your child has, or presently had:**

Heart (Surgery, Disease, Attack)	Yes☐ No☐	Latex Sensitivity.....	Yes☐ No☐	Hepatitis If Yes Type_____.....	Yes☐ No☐
Chest Pain.....	Yes☐ No☐	Stomach Ulcers.....	Yes☐ No☐	Liver Disease.....	Yes☐ No☐
Congenital Heart Disease.....	Yes☐ No☐	Diabetes If Yes Type _____.....	Yes☐ No☐	Yellow Jaundice.....	Yes☐ No☐
Heart Murmur.....	Yes☐ No☐	Thyroid Problems…Hyper/Hypo	Yes☐ No☐	Venereal Disease.....	Yes☐ No☐
High Blood Pressure.....	Yes☐ No☐	Glaucoma.....	Yes☐ No☐	A.I.D.S.....	Yes☐ No☐
Artificial Heart Valve.....	Yes☐ No☐	Emphysema.....	Yes☐ No☐	H.I.V. Positive.....	Yes☐ No☐
Mitral Valve Prolapse.....	Yes☐ No☐	Chronic Cough.....	Yes☐ No☐	Cold Sores / Fever Blisters.....	Yes☐ No☐
Heart Pacemaker.....	Yes☐ No☐	Tuberculosis.....	Yes☐ No☐	Blood Transfusion.....	Yes☐ No☐
Rheumatic Fever.....	Yes☐ No☐	Asthma.....	Yes☐ No☐	Hemophilia.....	Yes☐ No☐
Arthritis / Rheumatism.....	Yes☐ No☐	Have you ever needed Premed.	Yes☐ No☐	Sickle Cell Disease.....	Yes☐ No☐
Cortisone Medicine.....	Yes☐ No☐	Allergies or Hives.....	Yes☐ No☐	Bruise Easily.....	Yes☐ No☐
Swollen Ankles.....	Yes☐ No☐	Sinus Trouble.....	Yes☐ No☐	Neurological Disorders.....	Yes☐ No☐
Stroke.....	Yes☐ No☐	Radiation Therapy.....	Yes☐ No☐	Epilepsy or Seizures.....	Yes☐ No☐
Are you taking Blood Thinners..	Yes☐ No☐	Chemotherapy.....	Yes☐ No☐	Fainting or Dizzy Spells.....	Yes☐ No☐
Artificial Joints (hip, knee etc)...	Yes☐ No☐	Tumors.....	Yes☐ No☐	Nervous / Anxious.....	Yes☐ No☐
Kidney Trouble.....	Yes☐ No☐	Do You Smoke.....	Yes☐ No☐	Psychiatric / Psychological Care	Yes☐ No☐

6. **Do you have, or have you had and medical conditions not listed?** Yes☐ No☐

   If Yes, please list_____

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any changes in my health or medication.

Patient / Guardian Signature _____ Date_____ /_____ /_____
Day Month Year

TURN OVER →

SIERRA SPRINGS DENTAL

7. **Please check yes or no to the following questions:**

Does your child have any dental problems?	Yes☐ No☐	If Yes, please explain: _____
Has your child been to the dentist before?	Yes☐ No☐	If Yes, please explain: _____
Has your child ever had a serious/difficult problem associated with dental work?	Yes☐ No☐	If Yes, please explain: _____
Does your child have a finger or thumb habit?	Yes☐ No☐	If Yes, please explain: _____
Has your child ever had an injury to the face or jaw?	Yes☐ No☐	If Yes, please explain: _____
Are you happy with the appearance of your child's teeth?	Yes☐ No☐	If Yes, please explain: _____

How often does your child brush? _____ How often does your child floss? _____

TREATMENT CONSENT

I, the under signed, authorize Sierra Springs Dental to perform any necessary dental services and oral surgery that I may need during my diagnosis and treatment with my informed consent. I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. I also understand that any and all dental services are my sole responsibility and that I should make myself aware of any fees associated with my dental care prior to treatment.

Your appointment time will be reserved especially for you. If you are unable to keep your scheduled visit **we require a minimum of 2 business days notification**. Advance notice allows our office to see other patients who may have been waiting to see us for needed treatment. We thank you in advance for your consideration. **A charge of $50.00 may apply to your account if sufficient notice is not provided.**

_____	_____	_____
Patient/Guardian Name	Signature of Patient/Guardian	Date

INSURANCE

Primary Name of Policy Holder: _____ Date of Birth: _____
Insurance company: _____
Insurance Year End: _____ Group/Policy #: _____ ID/Certificate #: _____
Annual maximum: $_____ Annual deductible: $_____
Percentage coverage: Basic: _____% Major: _____%
Secondary Name of Policy Holder: _____ Date of Birth: _____
Insurance company: _____
Insurance Year End: _____ Group/Policy #: _____ ID/Certificate #: _____
Annual maximum: $_____ Annual deductible: $_____
Percentage coverage: Basic: _____% Major: _____%

INSURANCE (Important)

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**. I hereby agree to the Financial Policy of Sierra Springs Dental as outlined above and authorize Sierra Springs 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: _____

SIERRA SPRINGS DENTAL

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 option.
- 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.

_____	_____	_____
Patient/Guardian Name	Signature	Date