CHILD INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide your dental services.
Please complete forms and email to info@toothville.ca

Child's Name: _____ Date of Birth: DD/MM/YYYY Sex: _____ Age: _____

Home Address: _____ City: _____ Postal Code: _____

Home Phone: _____ School: _____

Email: _____

WHOM MAY WE THANK FOR YOUR REFERRAL: _____

MOTHER / FATHER INFORMATION

Mother's Name: _____ Father's Name: _____

Mother's Employer: _____ Father's Employer: _____

Mother's Mobile Phone: _____ Father's Mobile Phone: _____

YOUR DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Company Name: _____

Subscribers/Policy Holders Name: _____ DOB: DD/MM/YYYY

Group#_____ ID or CERT#_____ Coverage: Basic %____ Major %____ Maximum/Yr ____

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: DD/MM/YYYY

Group#_____ ID or CERT#_____ Coverage: Basic %____ Major %____ Maximum/Yr ____

What restrictions do you have on your dental plan?

(ie. How often is polishing covered? Is fluoride covered? How many units ofscaling arecovered?)

Name of your child' s Physician: _____

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

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

HAS YOUR CHILD EVER HAD AN ALLERGIC REACTION TO THE FOLLOWING?

Please check yes or no:	**Yes**	**No**
• Local Anesthetic (Freezing)	○	○
• Penicillin or other Antibiotics	○	○
• Codeine, Demerol or other narcotics	○	○
• Metals	○	○
• Latex	○	○

Please list any current medications, vitamins or supplements.

_____

DENTAL HISTORY

Please check yes or no to the following questions:

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

Tooth Ville Family Dentistry Privacy Policy Consent Form

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 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, home and/or 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 and/or legal guardians or persons financially responsible for patient accounts, for dental services, to process credit card payments, or to collect unpaid accounts.
- In To process claims for payment or reimbursement from third-party benefit providers, insurance companies and government agencies.
- 1, To send reminders to patients concerning the need for further dental examination or treatment. In 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 from whoever has been written as financially responsible for the account.

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:

- To all third-party benefit providers, insurance companies and government agencies where a claim is being submitted for reimbursement or payment of all or part of the cost of dental treatment.
- To other dentists and dental specialists, where further information and/or discussion is required.
- To other dentists and dental specialists if the patient has been referred by us to the other dentist of dental specialist for treatment.
- To other health care professionals such as physicians if the patient has been referred by us to the other health care professional for either a second opinion or treatment.
- Where we are seeking and/or providing information to the following: laboratories, radiology centres, hospitals, etc.
- To include the following when necessary, such as: videos, pictures, slides, etc., for educational purposes.

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 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 interests.

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

Patient/Guardian Signature _____ **Date** _____

ToothVille Family Dentistry Office Policies

Appointment Reminders

Please understand that it is your responsibility to keep track of your appointments. We will do everything we can to ensure you receive reminders, and have adequate time to make arrangements or change appointments.

Cancellations

We require a minimum of 24 hours notice to modify scheduled appointments, and 72 hours notice for Monday appointments. This is valuable time that has been reserved for you with the Dentist/Hygienist. In the event that insufficient notice is given, a charge of $50 may be applied to your account.

Direct Billing Insurance & Payment Arrangements

The Canadian Personal Privacy Act prohibits us from accessing information from most insurance carriers. As every policy is unique, it is your responsibility to know the details of your plan (annual maximums, frequencies, other limitations). We do direct bill to insurance as a courtesy, and will submit pre-determinations (estimates) for major treatment, however, it is important that you understand the details of your policy to utilize your benefits to their maximum and avoid any discrepancies.

I have read the above information and understand the office policies.

Signature: _____ Date: _____

Below are 2 payment options available to you. Please CHECK the option you would like to participate in.

Option 1 ◯ Payment is due in full on the day the treatment is completed. We accept cash, Debit, MasterCard & Visa. Your payment will be processed and insurance documents will be generated and submitted to your insurance carrier. Your Insurance carrier will pay you directly.

Option 2 ◯ We will direct bill your insurance carrier. If we receive an explanation of benefits from your insurance carrier following your visit, the outstanding balance will be collected before you leave. You will be required to leave a credit card on file. If there is a balance on your account following insurance payments, it will be charged to the card on file and a receipt for payment will be emailed to you. **A credit card is not required for Alberta Works.**

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 ToothVille Family Dentistry as outlined above, and authorize ToothVille Family Dentistry 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** ☐ **MASTERCARD**

Card#: _____ **Exp. Date:** _____ **CVV:** _____

Name on card: _____

Authorized Signature: _____