Date: _____

MEDICAL ALERT

WELCOME TO SOUTHBROOK DENTAL GROUP

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form.

PLEASE PRINT

Registration Information

Male□ Female□

Child's Name:_____

Date of Birth:_____ Alberta Health Care Number:_____
(DD/MM/YYYY)

Mailing Address:_____

City:_____Province:_____ Postal Code: _____

Home Phone: _____Cell Phone: _____Emergency Phone:_____

Email: (required for appointment reminders/confirmations)_____

Emergency Contact:_____Relationship:_____Phone:_____

Is there a dental problem you would like treated immediately? If so, what time would you prefer for appointments? _____

_____

Are other family member's patients at our office? Yes □ Names: _____

How did you hear about our office? □ Friend/Relative □Yellow Pages □Advertising □Other: ___

_____

Parents/Guardian Information

Name:_____
Marital Status:_____
Date of Birth (DD/MM/YYYY):_____
Relationship to child:_____
Mailing Address:_____
Employer:_____
Work Phone:_____
Home Phone:_____
Cellular:_____
E-Mail Address: _____

Name:_____
Marital Status: _____
Date of Birth: (DD/MM/YYYY)_____
Relationship to child:_____
Mailing Address: _____
Employer:_____
Work Phone:_____
Home Phone: _____
Cellular:_____
E-Mail Address: _____

Insurance Information

Primary Insurance

Subscriber: _____
Relationship to child:_____
Insurance Information:_____
Policy Group Plan Number:_____
Contract ID/Subscriber Number: _____

Secondary Insurance

Subscriber:_____
Relationship to child:_____
Insurance Company: _____
Policy Group Number:_____
Contract ID/ Subscriber Number:_____

Date: _____

Dental History- ***Please mark off YES or NO to each question.***

If unsure please consult with the dentist or receptionist

Why did you bring your child to us today?_____

Is this your child's first visit to a dentist? □YES □NO

If no, previous dentist:_____

Date of last appointment:_____Were any X-Rays taken? □YES □NO

Does your child brush their teeth on their own? □YES □NO

How often are your child's teeth being brushed?_____

Flossed?_____

Does your child have any bad habits such as:

□ Thumb Sucking □ Mouth breathing

□ Lip biting □ Teeth Grinding?

Have any cavities been noted in the past? □YES □NO

Were any baby teeth removed by extraction? □YES □NO

Have there been any injuries to the teeth, such as falls, hits, or chips? If so describe: _____

_____

_____

Has anyone in your family in the past had orthodontic treatment? □YES □NO

Has your child ever received local anaesthetic (freezing)? □YES □NO

Does your child think there is anything wrong with his/her teeth? □YES □NO

Medical History Please mark off YES or NO to each question.

If unsure please consult with the dentist or receptionist

1. Name of pediatrician or family physician: _____ Phone: _____

2. Is your child currently taking any medication or drugs? _____

If yes, state why and list: _____

3.Has your child ever had a bad reaction to drugs including antibiotics or local/general anesthetics? □YES □NO

if yes, explain:_____

4. Does your child have any allergies? _____

5. Has your child had any serious illness? _____

If so, When?_____ What?_____

6. Does your child experience severe or prolonged bleeding? _____

7. Is your child subject to nervous disorders? _____

8. Has your child recently had any of the following? *(Indicate approximate date)*

Measles: YES NO Date:	Strep Throat: YES NO Date:
Mumps: YES NO Date:	Tonsillitis YES NO Date:
Chicken Pox: YES NO Date:	

9. Does your child have or ever been diagnosed with any of the following conditions? (please circle)

AIDS/HIV	Bleeding Disorder	Epilepsy	Rheumatic/Scarlet Fever
ADD/ ADHD	Cancer	Eye Problems	Seizures
Allergies	Cerebral Palsy	Hearing Loss	Sickle Cell Anemia
Anemia	Cleft Lip/Palate	Heart Disease/Murmur	Speech problems
Asthma	Developmental Delays	Liver Disease	Tuberculosis
Autism	Diabetes	Mentally Cognitive	

Date: _____

10. Is there anything else we should know about your child's health or medical conditions? _____

_____

_____

_____

OFFICE POLICY

APPOINTMENTS

Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore at least 48 HOURS notice must be given if cancellation is absolutely necessary.

PAYMENT OF FEES

1. This office is willing to accept direct payment from you dental insurance plan for services which your plan covers if authorization is given to directly pay dental office.
2. If you're dental plan does not cover the full cost of your treatment, you will be responsible for any difference between the amount paid by your plan and the amount charged.
3. Your portion is then due and payable on the day of your appointment unless other financial arrangements have been made.
4. You are responsible for providing the necessary information in order for us to direct bill your insurance company as well as informing us of any changes in this information.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical dental history and have not knowing omitted any information.

CONSENT

I, the undersigned, herby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of my child's dental needs. I authorize the doctor to perform any and all forms of treatment, medication, and therapy that are indicated and consent to the local anaesthetic agents. I understand the above statements regarding the payment of fees and accept the responsivity for payment of dental services provided for myself or my dependents, due and payable services are rendered, unless other financial arrangements have been made.

Parent/Guardian Signature:_____ *Date:* _____ *Witness signature:* _____