Patient Information – children ages 6 to 15

Last name: _____ **First name:** _____ **Preferred name:** _____

Male ☐ **Female** ☐ **Birth date (DD/MM/YYYY):** _____ **Health card #:** _____

MOTHER's last name: _____ **MOTHER first name:** _____ **Date of birth** _____

FATHER's last name: _____ **FATHER first name:** _____ **Date of birth** _____

GUARDIAN'S last name: _____ **GUARDIAN'S first name:** _____ **Date of birth** _____

Who do we contact to schedule appointments? _____

Preferred method of contact: E-mail ☐ Home # ☐ Mobile # ☐ Work # ☐ Text msg ☐

Home ph: _____ **Mobile ph:** _____ **Work ph:** _____ **Ext.** _____

E-mail address for automated reminders: _____

Address: _____ **City:** _____ **Postal code:** _____

Please indicate why you chose to come to our office

Friend recommendation/referral (please specify so that we may thank them)	
Family comes here	
Convenient location	
Internet (Google, Rate MDs, our website, Facebook, etc.) --- please specify	

Insurance Information

Dental insurance company name | policy | ID numbers: _____ | _____ | _____

(Provide secondary insurance plan information to receptionist)

Name/date of birth of plan member: _____

Patient's relationship to insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Medical Information

Medical doctor _____ **Phone:** _____ **Last medical exam?** _____

Previous dentist _____ **Phone:** _____ **Last dental exam?** _____

MEDICATIONS: list prescription **AND** non-prescription medications

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ALLERGIES: list all allergies or adverse reactions to **ANY** substance

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Is the patient generally in good health?	Yes	No
Have there been any changes in general health within the year?	Yes	No
Is the patient now under physician care?	Yes	No
Has the patient ever had a serious illness or operation?	Yes	No
Has the patient been hospitalized within the past 5 years?	Yes	No
Does the patient have an infectious or communicable disease?	Yes	No
Does the patient suffer from dental anxiety?	Yes	No

Please indicate if any of the following are present:

Trouble hearing	Trouble seeing	History of ear, nose, and throat problems	
Persistent thirst	Severe headaches	Can't lie down all the way	
Difficulty swallowing	Acid reflux	Recent change of appetite	
Frequent vomiting	Extra pillows to sleep	Urinate more than 6 times per day	
Headaches	Sinus troubles	Tendency to faint	
Hard to freeze	Jaw stiffness		
Facial pain	Sleep apnea	Jaw Pain	Headaches
Bleeding gums	Sensitive teeth	Earaches	Neck Pain
Braces	Invisalign	Retainers	Mouth guard
Biteplane/night guard	Dentures/Partials	Crowns/bridges	Implants

Indicate dental product use:

Manual toothbrush	☐	Two or more times a day	☐	Once a day	☐	Three times a week	☐	Rarely	☐ Never
Electric toothbrush	☐	Two or more times a day	☐	Once a day	☐	Three times a week	☐	Rarely	☐ Never
Dental floss	☐	Two or more times a day	☐	Once a day	☐	Three times a week	☐	Rarely	☐ Never

Please Initial and Sign

_____ To the best of my knowledge, the medical and dental history provided is true and correct. I will provide information on changes in health.

_____ I authorize the diagnosis of dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

_____ I give consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by her supervised staff for diagnostic purposes or dental treatment.

_____ I authorize the dentist to release information to other healthcare practitioners and insurance carriers. If there is a specific person(s) who should not receive the patient's dental records, please notify us.

_____ I am financially responsible for ALL services provided; payment-in-full is expected on the day of the visit. Bedford South Dentistry will send dental claims online; benefits will be paid to the plan member.

_____ I understand that the dentist and staff do not know the details of my dental benefits plan as it is protected under privacy regulations. It is my responsibility to understand my plan.

IMPORTANT:

The provincial Children's Oral Health Program, funded by Nova Scotia Medical Services Insurance (MSI) is a government subsidy that will cover a portion of children's dental care - 1 exam, 2 x-rays, and 15 min. of hygiene once every 365 days, plus basic restorative services. This may be adequate for tiny children, but as children grow older they require more than 15 minutes of hygiene; parents are responsible for the cost of any additional hygiene services.

Be advised that claims must always be sent to private insurance first before sending to MSI (private insurance must be used up before we are permitted to submit claims to this government program for consideration). If you do not have private insurance, your child's second visit in the year does not qualify for coverage with the COHP.

The Canadian Dental Association recommends that children visit the dentist at 6 month intervals for diagnostic and preventative care. Small lesions on teeth (small enough that they may not be detected at one visit) can grow large enough in 6 months for a baby tooth to abscess.

***A charge of $80 will apply for failure to attend a pre-booked appointment or for failure to provide 48 hours' notice (2 business days) for schedule changes. This policy is essential for the efficient functioning of our dental office.**

Signed and dated: _____ Print name: _____

Dentist signature: _____

Bedford South Dentistry: Patient Consent for Records Release

Transfer of records from:

Previous dentist:

Address: _____

Fax number: _____

E-mail address:
(even better! ☺) _____

New dentist: Dr. Natalie Brothers Dr. Jillian Reynolds Dr. Bonnie Theriault Dr. Allison Thibault
(circle)

Address: Bedford South Dentistry
15 Peakview Way, Suite 300, Bedford, N.S. B3M 0G2
Phone: (902) 433-6825 Fax: (902) 835-3831

E-mail: reception@bedfordsouthdentistry.com

*****IF YOU ARE ABLE, PLEASE SEND X-RAYS IN DEXIS FORMAT*****

I hereby give authorization to release a copy of my dental records to the above-named dentist.

Patient(s) (family) name(s) PLEASE PRINT	Patient(s) dates of birth USE DAY/ MONTH/YEAR FORMAT

Patient address: _____

Patient phone: _____

Patient signature: _____

Date: _____