Patient Registration Form

General Information

Patient's Name:		Gender	Male Female	Patient's Date of Birth: (DD/MM/YY)	
Name of Father / Guardian:		Name of Mother / Guardian			
Street Address:					
City		Province		Postal Code	
Home Phone		Cell Phone		Work Phone	
E-mail					

Whom may we thank for referring you to our practice?	
Were you referred by another dentist? If so, please explain the reason for the referral:	Yes No
Please use this space to list any additional concerns, dental problems, or other information that you feel would be helpful to us in treating your child:	

Insurance / Financial Information

The following applies to patients with dental insurance:

For your convenience, our office is equipped for electronic claims submissions so that we can expeditiously estimate insurance coverage and process claims. Your insurance plan is a contract between you and your insurance company. Therefore, and like most specialty practices, we do not accept direct payment from your insurance company. We ask that payments be made at the end of each appointment, and will do our best to make sure that you are reimbursed quickly by your insurance company.

Primary Dental Insurance:		Secondary Dental Insurance:	
Insurance Co. Name		Insurance Co. Name	
Name of Policy Holder		Name of Policy Holder	
Employer Name, Phone #		Employer Name, Phone #	
Group/Policy Number		Group/Policy Number	
Member ID #		Member ID #	
Date of Birth (Policy Holder) (DD/MM/YY)		Date of Birth (Policy Holder) (DD/MM/YY)	

Medical History Information

Name of Pediatrician or Family Doctor:		Address:	
Phone Number:		Date of last physical examination:	

Is your child being treated currently, or within the past year, for any medical condition?	Yes No
Are your child's immunizations up to date?	Yes No
Is your child taking any medications? If Yes, please list:	Yes No
Has your child ever been hospitalized for any illness or operation? If Yes, please explain:	Yes No
Does your child have any allergies (medications, latex/rubber products, food, other) If Yes, please list:	Yes No

Does your child have currently or a history of any of the following medical conditions? ***Please check:***		
Anemia or Blood Disorder	Chronic Ear Infections	Immune Disorders (AIDS, HIV, ARC)
Arthritis	Cleft Lip and Palate	Kidney Disease
Asthma	Convulsions/Seizures	Leukemia
ADD / ADHD	Diabetes	Mental Retardation
Autism	Down Syndrome	Neurological Problems
Behavioral Disorder	Emotional Disturbance	Nutritional Deficiency
Bladder Conditions	Epilepsy	Oral Ulcers
Blood Pressure	Excessive Bleeding Problem	Orthopedic Problems
Birth Defects	Excessive Gagging	Premature Birth
Bone or Joint Problems	Fainting or Dizziness	Rheumatic Fever
Brain Injury	Growth & Development Problems	Scoliosis
Bruising or Bleeding Easily	Hearing / Speech Problems	Sickle Cell Trait / Anemia
Cancer or Malignancies	Heart Disease	Spina Bifida
Cerebral Disorder	Heart Murmur	Syndrome
Child Abuse	Hemophilia	Tuberculosis
Chronic Adenoid/Tonsil Infection	Hepatitis / Liver Disease	

Does your child have currently or a history of any other medical conditions not listed on previous page? If so, please explain:	

Dental information

Question	Answer
Does your child brush daily?	Yes No
Does your child floss daily?	Yes No
Has your child ever had any injuries to his teeth, mouth, head, or jaws? If yes, describe:	Yes No
Does your child have any of the following mouth habits? **Please check**	Pacifier, Finger Sucking, Thumb Sucking, Tongue Thrusting, Lip Sucking, Mouth Breather, Teeth Grinding
Does your child receive fluoride in any of the following forms? **Please check**	Vitamins, Water Supply, Toothpaste, Rinse/Gels, Tablets/Drops
How do you expect your child to react to today's visit? **Please check**	Excellent, Good, Fair, Poor, Don't Know
How may we help to make this a positive experience for your child?	

Consent for Dental Treatment

Please read this form carefully before signing. Prior to starting any treatment, we will confirm that you understand treatment options, including risks, benefits, and alternatives. If you have any questions, please ask.

Diagnosis

In order for our dental team to properly diagnose your child's dental and oral health condition, the following may be necessary

- Dental and oral examination
- Radiographs (x-rays) to diagnose and treat dental conditions as well as growth and development
- Photographs

Prevention

To optimize your child's oral health condition and to reduce the risk of disease and dental decay, the following treatment may be rendered

- Prophylaxis (cleaning)
- Fluoride application
- Dental Sealants

Treatment

Common dental treatment for pediatric patients includes

- Composite restorations (white fillings)
- Stainless steel crowns (for teeth that have significant decay and/or were treated with pulpotomies)
- Pulp therapy (nerve treatment may include pulpotomies or pulpectomies [root canals] to treat teeth with deep decay or that were traumatized)
- Extraction (may result in damage to adjacent and/or permanent teeth, pain, swelling, bleeding, nerve/jaw damage)
- Space maintainer appliances - appliances made to hold space when primary (baby) teeth are lost early
- Nitrous Oxide "laughing gas" Inhalation – may be used to help a child relax and cope with dental treatment. May result in nausea, vomiting, tingling of the hands and feet.

Behaviour Management

Dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Fini will provide an environment that will help children learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones.
Restraint / Immobilization–for the patient's safety to reduce unwanted movement, Dr. Fini and her staff may need to use restraint devices (for example, mouth props) or may need to physically hold the child still. Restraint will only be used when absolutely necessary.

Risks of Refusing Treatment

You have the right to refuse treatment; however, delayed treatment may allow for undiagnosed conditions, progression of dental disease, abscess formation, infection, fever, risk of damage to permanent teeth.

Complications of Dental Treatment

The usual and most frequent risks or complications occurring from dental treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury or permanent numbness, and allergic reactions.

Name of Patient: ________________________________ Date: ______________________________

Name of Parent/Guardian: ________________________ Signature: __________________________

Privacy Statement & Consent

Privacy of our patient's personal information is important to us. We are committed to collecting, using, and disclosing personal information responsibly.

Personal Information

Personal information for our purposes is; that information necessary for the provision of professional oral health care services provided to you, and information necessary to administer this dental practice. Personal information includes all that information provided by you to us on our patient information/health/medical history form at the first visit and any subsequent visits. Personal information may also include any information provided by you to us during the normal course of communication between patient and dental office staff. We will use and disclose only information provided to us by you or another person acting on your behalf.

Information Protection

We are committed to protecting your personal information. We have established and implemented a variety of security measures to properly manage and safeguard your personal information from loss, theft and unauthorized access. Access to your personal information shall be on a "need to know" basis.

Information Disclosure

Your personal information shall be disclosed to only those who have a need to know and them specific information disclosed shall be restricted to only that information relevant to the recipients need to know. Those who have a need to know include other dentists and health care providers (i.e. dental specialists, personal physicians). Further, the personal information disclosed to dental benefit providers is limited to only that personal information required by the provider. You may at any time designate any restrictions as to whom we may disclose your personal information or restrict the content of a disclosure.

Information Retention and Destruction

We will retain your personal information for the period necessary to continue providing oral health services to you, and for its related administration. We will destroy information in a secure manner when the information is no longer necessary for the provision of oral health services and is not required to be retained for compliance with provincial or federal regulations or statutes.

Your Access to Your Records

We are committed to providing you with open access to your personal information held by us. You may at any time ask us to see your records held by us and to request amendments to that information. We will provide access to you within a reasonable timeframe recognizing your desire for the information and our need to carry on our practice with limited interruption.

Complaint Process and Contact

Should you wish to make a formal complaint regarding our privacy practices, please do so in writing to our privacy officer, Dr A. Fini. Should you have any questions comments or concerns, please bring them to our attention. We will be pleased to assist you.

CONSENT ACKNOWLEDGEMENT

Having read and understood the above PRIVACY STATEMENT, I consent to the collection, use and disclosure of my personal information as presented in the statement, subject to the restrictions identified below.

Restrictions (if any) ____

Name of Patient: ______________________ Date: ______________________

Name of Parent/Guardian: ______________________ Signature: ______________________