Patient Information – children ages 6 to 15

PATIENT'S NAME: Last	Fi	rst:	Middle Initial:	
PREFERRED NAME:		PATIENT'S DOB (D/M/Y)	: AGE:	
GENDER: PREF. PRC	DNOUNS:			
VALID NS HEALTH CARD NUMBER:				
PATIENT'S ADDRESS:				
CITY:				
CONTACT #: C:				
EMAIL:				
INSURANCE INFO: COMPANY:				
RELATIONSHIP TO INSURED:			•=•••, •= •	
PARENT, SPOUSE OR LEGAL GUARDIA	AN (If under the age o	of 18)		
FULL NAME:		RELATIONSH	P TO PATIENT:	
ADDRESS: SAME AS ABOVE				
CONTACT #: C:	H:	V	V:	
DOB (D/M/Y):	EMAIL	:		
INSURANCE INFO: COMPANY:		PLAN/GROUP #	CERT/ID#	
FULL NAME:				
ADDRESS: SAME AS ABOVE				
CONTACT #: C:	H:	V	V:	
DOB (D/M/Y):	EMAIL	:		
INSURANCE INFO: COMPANY:		PLAN/GROUP #	CERT/ID#	
	Friend recommer	ndation/referral (please sp	ecify so that we may thank them)	
	Family comes her			
Please indicate why you chose to come to our office	Convenient locat	ion		
to come to our office	Internet (Google,	Rate MDs, our website, F	acebook, etc.) please specify	
Medical Information				
Medical mornation				
Medical doctor		Phone:	Last medical exam?	
Previous dentist		Phone:	Last dental exam?	
MEDICATIONS: list prescription AND	non-prescription me	dications		
ALLERGIES: list all allergies or advers	se reactions to <u>ANY</u> su	ubstance		
Is the patient generally in good heal			Yes No	
Have there been any changes in gen		year?	Yes No	
Is the patient now under physician c Has the patient ever had a serious ill			Yes No Yes No	

No

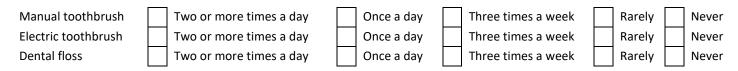
Has the patient even had a serious inness of operation:HesHas the patient been hospitalized within the past 5 years?Yes

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 app	petite
Frequent vomiting	Extra pillows to sleep	Urinate more than 6	times per day
Headaches	Sinus troubles	Tendency to faint	
Hard to freeze	Jaw stiffness	Jaw Pain	
Facial pain	Sleep apnea	Headaches	Neck Pain
Bleeding gums	Sensitive teeth	Earaches	Mouth guard
Braces	Invisalign	Retainers	Implants
Biteplane/night guard	Dentures/Partials	Crowns/bridges	

Indicate dental product use:



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 <u>not</u> 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 <u>portion</u> of children's dental care - 1 exam and 2 bitewing x-rays every 365 days, as well as 1-2 units (15-30 minutes) of scaling based on the age of the child and 2 fluoride treatments a year, plus <u>basic</u> restorative services. This may be adequate for tiny children, but as children grow older they may require more than 1-2 units of hygiene; parents are responsible for the cost of any additional services not eligible under the MSI program. I will provide valid credit card information at my first visit and authorization for use in the event that payment is needed for account balances for services not covered by insurance. *Be advised that claims <u>must always be</u> 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).

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 \$102 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 love your smile 15 Peakview Way Unit 300, Bedford South, NS, B3M 0G2 4-DENTAL(433-6825) www.bedfordsouthdentistry.com Dr. Natalie Brothers Dr. Jillian Reynolds Dr. Bonnie Theriault Dr. Allison Thibault reception@bedfordsouthdentistry.com

Patient Records Consent Form

Patient First Name:	Patient last name:
Patient Date of Birth:	
Transfer of records from:	
Previous dentist:	
Address:	
Fax number:	
E-mail address:	
I hereby give authorization to release a copy	of my dental records to the above-named clinic.

Patient signature: Date:

The following to be completed by the previous dental office:

E-mail:

The above patient has come to our office for continuing dental care. Kindly forward dental information with recent radiographs and chart notes. ***IF YOU ARE ABLE, PLEASE SEND X-RAYS IN DEXIS FORMAT ***

Date of last complete oral exam:	
Date of last bitewing radiographs:	
Date of last Panorex radiograph:	
Date of last recall exam:	
Date of last hygiene appointment:	