Patient Information – children ages 6 to 15

PATIENT'S NAME: Last_____ **First:**_____ **Middle Initial:**_____

PREFERRED NAME: _____ **PATIENT'S DOB (D/M/Y):** _____ **AGE:** _____

GENDER:_____ **PREF. PRONOUNS:** _____

VALID NS HEALTH CARD NUMBER:_____

PATIENT'S ADDRESS: _____

CITY: _____ **PROV:** _____ **POSTAL CODE:** _____

CONTACT #: C: _____ **H:**_____ **W:**_____

EMAIL:_____ **PREF. CONTACT METHOD:** _____

INSURANCE INFO: COMPANY:_____ **PLAN/GROUP #**_____ **CERT/ID#**_____

RELATIONSHIP TO INSURED: _____

PARENT, SPOUSE OR LEGAL GUARDIAN (If under the age of 18)

FULL NAME: _____ **RELATIONSHIP TO PATIENT:**_____

ADDRESS: ☐ **SAME AS ABOVE** _____

CONTACT #: C: _____ **H:**_____ **W:** _____

DOB (D/M/Y): _____ **EMAIL:** _____

INSURANCE INFO: COMPANY:_____ **PLAN/GROUP #**_____ **CERT/ID#** _____

FULL NAME: _____ **RELATIONSHIP TO PATIENT:**_____

ADDRESS: ☐ **SAME AS ABOVE** _____

CONTACT #: C: _____ **H:**_____ **W:** _____

DOB (D/M/Y): _____ **EMAIL:** _____

INSURANCE INFO: COMPANY:_____ **PLAN/GROUP #**_____ **CERT/ID#** _____

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	

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	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:

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 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 basic 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 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).

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

E-mail: 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:
(even better! ☺) _____

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:

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:	