



Unit 101, 175 Chestermere Station Way Chestermere, AB T1X 0A4
email: pedo@stationdentistry.com
ph: 587.349.5858 fax: 587.349.5860

Pediatric Dentistry NEW PATIENT Information Please complete ALL areas

Patient Name: Birthdate: Gender: Female Male
Previous Dental Clinic: Date of Last Dental Exam:
Medical Doctor: Alberta Health Care #:
If your child was not referred to us by a specific dentist, how did you hear about us: Word of mouth Lifepath The Anchor
Facebook Internet search / Website Sibling is a patient Other

Dental History:

What is the primary reason for today's visit?
Is patient in pain? Yes No Explain:
Has patient had an injury to the mouth, teeth or jaw? Yes No Explain:
What is the patients primary water source: Private Well City Water: Other:
Was/is patient: Breastfed or Bottle fed Until what age? Breastfed: Bottle fed:
How often does patient brush teeth? With help Without help How often does patient floss?
Does Patient...
Sucks Thumb/Finger Clench/Grind Teeth Speech Issues Bite Finger Nails Use Pacifier Mouth Breather

Medical History:

Is patient currently under the care of a doctor? Yes No Explain:
Does patient have any allergies? Yes No Explain:
Is the patient taking any medications? (Including over the counter / herbal supplements) Yes No
Medication Name / Dosage / Frequency of use:
Has patient ever had surgery or been hospitalized? Yes No
Reason: When:

Does patient have/or had any of the following:

- Congenital Heart Defect / Disease
Heart Surgery
Heart Murmur
High Blood Pressure
Rheumatic Fever
Asthma / Breathing Issues
Cerebral Palsy
Seizures / Convulsions / Epilepsy
Learning / Communication Problems
Autism / Aspergers
ADD / ADHD
Visual / Hearing Impairment
Abnormal Bleeding Issues
Sickle Cell Trait / Disease
Hemophilia / Anemia
Kidney Problems
Liver Problems
Diabetes
Muscle / Bone / Joint Problems
Thyroid / Glandular Problems
Skin Problems / Hives / Cold Sores
Failure to Thrive
Eating Disorders
Born Prematurely
Immunizations
Hepatitis A, B, C
Blood / Blood Product Transfusion
HIV / AIDS
Varicella Vaccine / Chicken Pox
MRSA
TB / Tuberculosis
Limited Mobility
Other:

Are there any other medical conditions or concerns that we need to be aware of?

- I, the undersigned, confirm that I am the parent / legal guardian of the above child.
To the best of my knowledge all of the preceding answers and information provided are true, complete and accurate.
I grant permission to you and your assignees to telephone me to discuss matters related to this form.
I understand that this information is held in the strictest confidence and it is my responsibility to inform the office of any changes to my child's medical, insurance or legal guardianship status.

Signature of Parent / Legal Guardian

Date

Printed Name



## Pediatric Dentistry Family Information

### Family Information -- Please complete ALL areas

Mother Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Cell #: \_\_\_\_\_

Father Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Cell #: \_\_\_\_\_

OR Name of Legal Guardian: \_\_\_\_\_ DOB: \_\_\_\_\_ Cell #: \_\_\_\_\_

Primary Address: \_\_\_\_\_ City/Town: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Secondary Address: (if applicable) \_\_\_\_\_ City/Town: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

*If you are an appointed legal guardian, please provide the legal guardianship papers for our records. Note: Step-parents are not considered legal guardians unless the child has been legally adopted.*

### Our Appointment Policy

*Thank you for allowing Chestermere Station Pediatric Dentistry and Orthodontics the privilege of being your dental health provider. Our practice is dedicated to quality care and is pleased to reserve time exclusively for each patient.*

- We respect our patients' time and make every effort to remain on schedule. Despite careful scheduling, dental emergencies can cause delays. If your appointment time is affected due to an unforeseen emergency, we will try our best to notify you in advance. We know that your time, like our Doctor's, is valuable and we will make every effort to see you on time and will ensure you are given the same time and attention for your dental health.
- Because we reserve time exclusively for you, we ask that you make every effort to keep your reserved appointment time. If you find that you cannot keep your scheduled visit, we require a minimum of 2 business days' notification. Advance notice allows our office to see other patients who may have been waiting to see us for needed treatment. We thank you in advance for your consideration. A charge of \$75.00 may apply to your account if sufficient notice is not provided; this charge is at the discretion of your Dentist. initial

### Financial Policies for Dental Insured Patients

*Many of our patients have dental insurance. While your dental insurance policy is an agreement between you and your insurance company, we will be happy to assist you in preparing and sending in the necessary forms. Please remember that no insurance company attempts to cover all dental costs. We cannot render dental treatment on the assumption that our fees will be paid in full by an insurance company. Full payment to our office is your responsibility, regardless of how much your insurance does or does not pay.*

I am aware that Chestermere Station Dentistry direct bills my Insurance Company as a courtesy to me and that in doing so, the dental office accepts no responsibility for any uncovered amounts, amounts over benefit maximums, limitations or plan restrictions, etc. I understand that the dental office collects my dental coverage information as a guideline ONLY to assist me in maximizing my benefits this does not hold them responsible for my dental account. Chestermere Station advises that I make myself very aware of my dental plan, knowing my coverage and that I ask my dental team about any and all procedures I am authorizing. initial

Chestermere Station Dentistry advises me to contact my Insurance Company for questions regarding eligible procedures and authorization of treatment; and to make myself aware of all costs involved with my dental care. Chestermere Station advises me to keep track of my yearly maximums, limitations, and accumulated amounts used on my dental benefit plan. initial

**Payment is due at the time of service.** I am aware that if the dental office does not receive confirmation from my Insurance for their exact payment— Chestermere Station will estimate my portion only at the time of visit. Any unforeseen balances will then be informed to me by statement. I agree to pay all of these uncovered portions within **10 days** from the date of statement or interest charges of 5% per month may be applied to my account. I agree to pay these interest charges if applied to my overdue account. initial

I also understand that any uncovered procedures that may have been done at another Dental office are my responsibility. initial

**IMPORTANT:** Please be advised that complete oral examinations (new patient exams) & x-rays will be denied by your insurance IF you have had this procedure at another dental office within the time limitations of your specific plan. You are responsible for this procedure in our office should this not be an eligible benefit with your coverage. initial

### Consent for Treatment/Accountability Confirmation

**I authorize the dental office to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent. I, the undersigned, clearly understand all policies of Chestermere Station Dentistry. I understand and agree to pay all fees associated with my dental treatment. With or without dental coverage, I agree to make myself aware of those fees prior to authorizing any dental treatment to be done.**

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name



## **Pediatric Dentistry Personal Information Consent**

### **Dental Office Personal Information Consent Form – Privacy Act Information**

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers and e-mail addresses. (Collectively referred to as "Contact Information".) Contact information is collected and used for the following purposes:

- To open and update patient files
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts
- To process claims for payment or reimbursement from third party health benefit providers and insurance companies
- To send reminders to patients concerning the need for further dental examination or treatment
- To send patients informational material about our dental materials
- To follow up with treatment and/or customer services

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services. We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. (Collectively referred to as "Medical Information".) Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed for the following purposes:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf
- To other dentists and dental specialists where we are seeking a second opinion and the patient has consented to us obtaining the second opinion
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion
- To other health care professionals, such as physicians, if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment

If we are ever considering selling all or part of our dental practice, qualified, potential purchasers may be granted access, as part of the due diligence process, to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Pediatric Dentistry Insurance Information

### Insurance Information (or you may provide your insurance card for us to copy and keep on file)

**If your plan does not allow to pay the Dentist directly, you are responsible to pay in full for your treatment on the date of service.**

**Primary Plan - For children, the parent whose birth month comes first in the year is Primary plan**

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

ID or Certificate #: \_\_\_\_\_ Employer/Company Name: \_\_\_\_\_

Subscriber/Policy Holder's name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

### **Secondary Plan**

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_

ID or Certificate #: \_\_\_\_\_ Employer/Company Name: \_\_\_\_\_

Subscriber/Policy Holder's name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

### YOUR DENTAL INSURANCE



Canadian  
Dental  
Association  
L'Association  
dentaire  
canadienne

Many of us have dental plans available to us through our employers. These dental prepayment plans are referred to as "dental insurance" but they are not really insurance. They are a prepayment of benefits for a portion of the fees for dental services. More often than not, we do not know the specifics of these plans and we assume that the details are cut and dry.

One very important thing to note is that not all dental plans are the same. You should be aware that dental plans are actually a way whereby your employer prepays all or a portion of the costs of your dental care in advance, as part of your compensation package. It is also important to remember that dental plan coverage is not a form of insurance.

Alberta dentists have always been able to set their own fees, for the services they provide, based on their individual practice situation. The Alberta Dental Association and College has also provided practice management information and courses to dentists, to help them in determining costs and how to set fees. These fees are to be based on an individual dentists review of cost factors, such as the time needed to provide a service, the value of that service to the patient and the overhead costs of staff, materials, rent, loans, bank financing, insurance, and utilities among others. The fee should not be based on whether or not the patient has a dental plan, insurance or what fee the carrier of the dental plan will pay. Decisions on dental plans are usually made during meetings with employers or plan sponsors and employees. Dental plan carriers use different means, such as the ADA&C's Annual Survey of Dental Fees in Alberta, in setting the level of payment of covered services. Some plan carriers are still not paying their clients the updated level of fees based on the current "Survey of dental Fees in Alberta".

Try to get as much data as you can from your company or organization's plan administrator or carrier before visiting the dentist. As there are dozens of companies selling dental plans, you cannot expect dentists and dental office staff to know about your plan and the coverage that you carry. Dental offices are not agents or brokers for any dental plan carrier.

If you have concerns with the level of payment or coverage your dental plan carrier is giving you for services you should inform your human resource officer, union leader or employer. These are the people who work out the dental contract with your carrier and they may not be fully aware of your concerns.

It is unlikely that any dental plan would cover every service that you may need. But to leave the choice of your dental treatment to only what is covered in your dental plan, rather than what you and your dentist feel is appropriate, leaves your dental health and general well-being in the hands of your plan carrier instead of you and your dentist.