SmileTown
Just Kids Dentistry

Patient and Contact Information

PATIENT INFORMATION

First Name _____ ☐M ☐F

Middle Name _____ Age _____

Last Name _____ D.O.B. _____

Address _____

City _____ Postal Code _____

Home Phone ( ) _____ What days and times are best to contact you?

Business Phone ( ) _____ Days _____

Cellular Phone ( ) _____ Times _____

Other ( ) _____

What is the best means to contact you by? _____

Email _____

CONTACT INFORMATION

Who is the best person to contact in case of emergency?

Name _____ Phone ( ) _____

Relationship to you _____

INSURANCE INFORMATION

Group / Policy Plan #_____

Certificate / ID # _____

Employer _____

Insuring Company _____

Subscriber Name _____

Subscriber D.O.B. _____/_____/_____ (mm/dd/yyyy)

SECONDARY INSURANCE INFORMATION

Group / Policy Plan #_____

Certificate / ID # _____

Employer _____

Insuring Company _____

Subscriber Name _____

Subscriber D.O.B. _____/_____/_____ (mm/dd/yyyy)

MEDICAL CARE INFORMATION

Family Dentist Dr. _____

Family Physician Dr. _____

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Medical Questionnaire – for Child

Today's Date: _____

Name _____ DOB (DD/MM/YY) ____/____/____

1. Does your child wear a medic alert bracelet? Please specify. YES ◯ NO ◯

2. Has your child had any COUGH or COLD within the last two weeks? YES ◯ NO ◯

3. Has your child had/have: YES ◯ NO ◯

heart disease ☐ liver disease ☐ kidney disease ☐ diabetes ☐

If yes, please explain.

4. Has you child had any of the following breathing problems: YES ◯ NO ◯

asthma ☐ pneumonia ☐ bronchitis ☐ cystic fibrosis ☐ croup ☐ sleep apnea ☐

If yes, please explain.

5. Has your child ever been prescribed any pills, liquids, or inhalers? YES ◯ NO ◯

If yes, please explain what medication(s) and when.

6. Is your child allergic to any pills, liquids, or inhalers? Please specify drug and reaction. YES ◯ NO ◯

7. Does your child have a latex sensitivity? Please specify reaction. YES ◯ NO ◯

8. Was your child born premature? Please specify. YES ◯ NO ◯

9. Has your child ever had an operation in the hospital? Please specify procedure and date. YES ◯ NO ◯

10. Has anyone in the immediate family (child's mother/father/siblings) had an operation in the hospital? YES ◯ NO ◯

Were there any complications or problems? Please specify. YES ◯ NO ◯

11. Does your child have special needs (i.e. Down Syndrome, autism, seizure disorder, cerebral palsy, other)? Please specify. YES ◯ NO ◯

12. Does your child live in a smoking environment? YES ◯ NO ◯

13. Has your child seen a physician in the past six months? YES ◯ NO ◯

For what reason?

Was any medication prescribed?

14. Are there any other medical issues, behavioural diagnosis, or other not mentioned so far? Please explain. YES ◯ NO ◯

Additional comments:

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____

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Financial Arrangements for Dental Treatment

- ***You are responsible for paying Dr. Stefan Ciz directly on the day of treatment for all your necessary dental and anaesthesia care. It is your responsibility to check with your insurance carrier about coverage.***

- We will *estimate* the amount of time required to complete the necessary dental treatment. *Anaesthesia fees are established on how long someone is asleep.* Based on Dr. Ciz's diagnosis a pre-treatment estimate can be submitted to you and your insurance company so that the level of reimbursement can be determined.

- Many children and patients with special needs will not allow us to complete a proper examination with x-rays until they are asleep. In these cases, an accurate diagnosis and estimate is impossible.

- ***Payment is expected at the end of anaesthesia on the day of treatment.*** Please bring all the necessary insurance information. If your insurance carrier allows for Electronic Data Interchange (EDI), we will complete the forms for you and submit them electronically.

- The following payment methods are available for your convenience: **CASH, VISA, MASTERCARD AND DEBIT AND IFINANCE**.

- ***We do not accept personal cheques due to frequent disappointment.***

- Some dental benefits do not reimburse at current year fee levels. In addition, some dental benefit plans do not reimburse for certain procedures or have restrictions. For example, some plans require a tooth to be removed before anaesthesia is covered. Other benefit plans cover anaesthesia regardless of the dental work performed. There are so many variations in plans that it is impossible to keep track.

- As there is a waiting list of patients and parents who all take time off work and take their children out of school for their dental anaesthesia appointment, missed appointments are not tolerated. **This time has been reserved for you and is subject to a fee if treatment cannot be completed. *This includes food being eaten on day of treatment.*** We require 48 hours notice to reschedule appointments. ***All missed appointments without proper notice are subject to a $250.00 fee.***

_____ _____

Print Name Signature

_____ _____

Date Signature of Witness

5 Meadowcreek Lane Cambridge ON N3H 4R8 • Ph: 519-749-9981 Toll Free: 877-749-9981

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Collection, Use and Disclosure of Personal Information

Our office understands the importance of protecting your personal information. This office will collect, use and disclose information about you for the following purposes:

- To enable us to contact you (your child) and to book and confirm appointments
- To advise you of treatment options
- To communicate with other health-care providers, including medical and dental specialists and general practitioners
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the *Regulatory Health Professions Act.*
- To comply with agreements/undertakings entered into voluntarily by Dr. Stefan Ciz with the Royal College of Dental Surgeons of Ontario, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
- To prepare material for the Health Professions Appeal and Review Board
- To process credit card payments
- To collect unpaid accounts

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

By signing the consent section of this form, you have agreed that you have given your informed consent to collection, use and/or disclosure of your personal information for the purposes that are listed.

PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information. I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that Dr. Stefan Ciz can collect, use and disclose personal information as set out above in the information about the office's privacy policies according to the requirements of the Regulated Health Professions Act, the Royal College of Dental Surgeons and privacy legislation.

_____ _____

Print Name Signature

_____ _____

Date Signature of Witness

Print Form

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