CARE CARD: _____ Date: _____ D / M / Y

PERSONAL HISTORY

All of the information which you provide on this form will be held in the strictest confidence. Although some questions may seem unimportant at the time, they may be vital in an emergency situation. Please ANSWER EACH QUESTION. Please ask the receptionist if you need assistance completing this form.

Patient's Name: _____ Usually Called: _____

Birth Date: _____ Place of Birth: _____
D / M / Y

Mailing Address: _____ City: _____ Postal Code: _____

Best Contact Ph#1: _____(C/H/W) Best Contact Ph#2: _____(C/H/W) Best Contact Ph#3: _____(C/H/W)

E-mail : _____

School: _____ Grade: _____

Sibling (Names and Ages): _____

Do the parents and children all live together? ❑ Yes ❑ No Emergency Contact: _____ Phone: _____

Parent/Legal Guardian Name: _____ Occupation: _____

Employer: _____

Residence Address: ❑ Same as child or _____ City: _____ Phone: _____

Parent/Legal Guardian Name: _____ Occupation: _____

Employer: _____

Residence Address: ❑ Same as child or _____ City: _____ Phone: _____

Purpose of visit: _____

Other children seen in this office? _____

Whom may we thank for this referral? _____

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it will be necessary to charge for the time lost. CANCELLATIONS WILL NOT BE ACCEPTED ON THE ANSWERING MACHINE. Regardless of insurance coverage, we require that services are paid for at each visit as they are performed.

PLEASE INDICATE ONE OF THE FOLLOWING:

❑ I have dental insurance ❑ No insurance

❑ DIA Status #_____ ❑ My child is covered under a Government Assistance Program

DENTAL INSURANCE FIRST COVERAGE

Employee: _____ Birth Date: _____

Employer: _____ Name of Insurance Company: _____

Policy or Group #: _____ ID or certificate # _____ Dependent # _____

DENTAL INSURANCE SECOND COVERAGE

Employee: _____ Birth Date: _____

Employer: _____ Name of Insurance Company: _____

Policy or Group #: _____ ID or certificate # _____ Dependent # _____

I authorize the doctor to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize the release of information concerning my child's health care, advice and treatment provided as it directly or indirectly relates to care in our office, from referring practitioners to our office, and from our office to other health care practitioners as deemed necessary for care, as well as for the purpose of evaluating the administering claims for insurance benefits.

I understand that my dental insurance carrier or payor of my dental benefits may pay less than that actual bill for services. I understand that I am financially responsible for payment in full on all accounts. I understand that Dr. Farquhar is a certified specialist and that fees may be generally higher than general practice fees. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental payor. I attest to the accuracy of the information on this page. The information given here is subject to the Personal Health Information Act in Canada.

Parent/Legal Guardian Signature _____ **Date** _____ D / M / Y

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REGISTRATION

Last edited Mar 2018

Patient's Name: _____Usually Called: _____Birth Date: _____
D / M / Y

MEDICAL HISTORY

1. Is your child under the care of a physician for a health problem at present? ……..……❍ Yes ❍ No

   If yes, since when and why? _____

   _____

2. Physician's name _____Phone _____

   Address _____

3. Has your child ever had a serious illness or been in hospital? ……❍ Yes ❍ No

   If yes, please explain: _____

4. Is your child receiving prescribed medication? ……❍ Yes ❍ No

   If yes, please explain: _____

5. Is your child receiving herbal supplements or homeopathic/naturopathic supplements? ……❍ Yes ❍ No

   If yes, please list:_____

6. If your child allergic to any medicine, drugs or food or had a bad reaction to any drug, medicine or food? ……❍ Yes ❍ No

   If yes, please list:_____

7. Is the child: ❑ biological ❑ adopted ❑ foster

8. Were there any problems during the pregnancy or during delivery? ……❍ Yes ❍ No

9. Does your child have problems *(Please check all that apply)*

   ❑ CONCENTRATING ❑ LEARNING ❑ COOPERATING ❑ UNDERSTANDING ❑ NONE OF THESE

10. Is there a history of domestic violence, spousal abuse, or child abuse? ……❍ Yes ❍ No

11. Are your child's immunizations up to date? ……❍ Yes ❍ No

12. Have you ever been told that your child has any of the following conditions? *(Please check all that apply)*

❑ ANEMIA	❑ CLEFT LIP/PALATE	❑ HIV (+)	❑ PNEUMONIA
❑ ASTHMA	❑ DIABETES	❑ HYPERACTIVE	❑ SEIZURES
❑ AUTISM	❑ DEVELOPMENTAL DELAY	❑ LATEX ALLERGY	❑ SPEECH PROBLEMS
❑ BIRTH DEFECTS	❑ EMOTIONAL DISORDERS	❑ LEUKEMIA	❑ TUBERCULOSIS
❑ BLEEDING	❑ EYESIGHT PROBLEMS	❑ LIVER PROBLEMS	❑ OTHER
❑ BLOOD TRANSFUSIONS	❑ FAINTING	❑ LUNG PROBLEMS	❑ _____
❑ BRAIN INJURY	❑ HEARING LOSS	❑ KIDNEY PROBLEMS	❑ _____
❑ CANCER	❑ HEART TROUBLE	❑ MALIGNANT HYPERTHERMIA	❑ _____
❑ CEREBRAL PALSY	❑ HEMOPHILIA	❑ MENTALLY CHALLENGED	❑ _____
❑ CHILD ABUSE	❑ HEPATITIS	❑ PHYSICAL HANDICAP	❑ _____

Parent/Legal Guardian Signature_____ **Dentist's Signature**_____ **Date** _____
D / M / Y

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MEDICAL HISTORY

Last edited Mar 2018

Patient's Name: _____Usually Called: _____Birth Date: _____
D / M / Y

DENTAL HISTORY

1. Has your child had previous dental treatment? ……❍ Yes ❍ No
   If so, how long ago? _____
2. Has your child ever had an unpleasant dental experience? ……❍ Yes ❍ No
   If yes, please explain? _____
3. Have there been any injuries to the teeth or mouth? ……❍ Yes ❍ No
   If yes, please explain? _____
4. Does your child have a toothache or other urgent dental problem? ……❍ Yes ❍ No
5. Is either parent nervous or anxious about their own dental treatment? ……❍ Yes ❍ No
6. Has your child ever received: ❑ Sedation ❑ Laughing Gas ❑ General Anesthesia

DENTAL DISEASE PREVENTION

1. When does your child brush his/her teeth?
   ❑ very seldom ❑ morning ❑ after eating any food ❑ right after meals ❑ before going to bed
2. Does your child use dental floss? ……❍ Yes ❍ No
3. Does someone (assist your child with tooth cleaning?) ……❍ Yes ❍ No
   (inspect for thoroughness of tooth cleaning?) ……❍ Yes ❍ No
4. Does your child use a fluoride containing toothpaste? ……❍ Yes ❍ No
5. Have you ever been taught how to floss or brush your child's teeth? ……❍ Yes ❍ No
6. Does your child eat sweets, drink soft drinks?
   ❑ less than once per week ❑ more than once but less than 4 times per week
   ❑ 4 - 7 times per week ❑ once per day ❑ more than once every day
7. How was your child fed as an infant? ❑ breast ❑ bottle age weaned _____ ❑ not yet weaned
8. Does/did your child ever have any of the following? *(Please check all that apply)*

❑ THUMB/FINGER SUCKING	❑ SNORING	❑ TOOTHACHES
❑ BOTTLE IN BED	❑ GAGGING	❑ PACIFIER USE
❑ CANKER SORES	❑ STAINED TEETH	❑ LISPING
❑ BAD BREATH	❑ LIP BITING	❑ COLD SORES
❑ TEETH GRINDING	❑ MOUTH BREATHING	

9. Is there a family history of: *(Please check all that apply)*

❑ MISSING OR EXTRA TEETH	❑ FEAR OF DENTISTRY
❑ GUM DISEASE	❑ HIGH TOOTH DECAY RATE

Parent/Legal Guardian Signature _____ **Date** _____
D / M / Y

Dentist's Signature _____ **Date** _____
D / M / Y

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DENTAL HISTORY

Last edited Mar 2018

Dr. Terry C.L. Farquhar
RN, D.D.S., Dip. Paed., F.R.C.D.C.
Certified Specialist in Pediatric Dentistry

FINANCIAL ARRANGEMENTS APPROVAL FORM

Patient: _____

I am aware that Dr. Terry Farquhar is a specialist in Pediatric Dentistry certified by the College of Dental Surgeons of British Columbia. The fees for dental treatment may be generally higher than those for a general practitioner and may be higher than those recognized by dental insurance companies or those covered by Government Assistance Programs.

I further understand that I am fully responsible for complete payment for all treatment costs regardless of the coverage provided by my dental insurance plan. The forms of payment which we accept are clearly outlined on the reverse side of this page.

All patients with dental insurance are responsible for payment of their accounts. We will gladly complete claims or estimate forms so that your insurance company may honour its commitment to you. We reserve the right to contact insurance companies about your coverage. Our office does not accept payment from insurance companies.

We do not accept uncertified personal cheques.

Your appointment time has been reserved especially for you. We require 2 business days notice for all cancellations or rescheduling. There may be a fee of $75.00 charged for short notice cancellations or missed appointments.

Considerable time and effort is expended by our staff when they book a hospital appointment for a patient. This is time spent in addition to the time taken during your child's examination appointment. For patients who cancel a **BOOKED** hospital appointment, regardless of when the cancellation is made, an administration fee of $50.00 will be applied to the family account.

CONSENT AND AGREEMENT

My signature below will certify that I have read and agree to the policies outlined on this form, that I agree to the performing of the dental procedures agreed to be necessary and that I am fully responsible for all fees and charges associated with my child's treatment.

It has been explained to me that payment is due at the time of service. Cash, VISA, Mastercard, Debit Card, Certified Cheque or Money Order may be used to pay for services rendered.

I agree to honour my financial obligation for complete payment:

_____ _____

Signature *Date*

_____ _____

Witness *Date*

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PLEASE SEE THE REVERSE SIDE FOR PAYMENT OPTIONS

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PAYMENT OPTIONS

In order to make payment services as convenient as possible for you while at the same time maintaining the operation of our office at the highest standard of comprehensive care, we offer several payment options. We will attempt to give you an accurate estimate of your fees prior to the commencement of treatment. **Please be advised that estimates for children who cannot be examined because of uncooperative behavior may not reflect the actual treatment required. In addition, an excessive delay in completing treatment may affect the cost of treatment.** Estimates for treatment will be honoured for 120 days from the date of issue. Should treatment occur after the estimate has expired, fees will be adjusted accordingly and may be higher. Outstanding treatment that is more than 6 months old will require that patient to have another examination prior to treatment completion. Fees will be adjusted accordingly to reflect the treatment required. Treatment to be completed in the operating room may be subject to longer wait times beyond our control, and as a result, treatment needs and treatment costs may change. **Your signature on this form serves as your acknowledgement that you understand and agree to be fully responsible for all fees and charges.**

We accept the following payment methods:
cash, debit, VISA, Mastercard, certified cheque, or ***money order.***

NOTE:
Dental Insurance. A pre-treatment estimate form will be provided to you to be submitted to your insurance carrier prior to treatment to obtain an estimate of your insurance benefits. If possible, we will submit the predetermination electronically to expedite your child's care. Please be aware that not all insurance companies accept electronic predeterminations. You will receive a written pre-determination outlining your insurance benefits. A copy will also be sent to our office. ***All patients with dental insurance are responsible for the payment of their accounts. We do not accept payment from insurance companies.*** We will gladly complete claim forms or estimate forms so that your insurance company can honour its commitment to you.

Please feel free to request clarification of any of the above options.

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