COCHRANE DENTAL CENTRE
Dr. David B. Sawka & Associates

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

1 About Your Child

Today's Date _____

Their Name: _____
Last First Initial

Prefer to be called: _____ ❑ Male ❑ Female

Birthday_____/_____/_____ Age _____
Month Day Year

Child's Home Address _____

_____
City Postal Code

Home Phone #: _____

Email: _____

School: _____

Special interests, sports or hobbies: _____

_____

2 Mother's Information

Name: _____
Last First Initial

Employer: _____

Work Phone #:_____ Ext: _____

Cell Phone #: _____

2 Father's Information

Name: _____
Last First Initial

Employer: _____

Work Phone #:_____ Ext: _____

Cell Phone #: _____

Who has legal custody of this child: _____

Who may we thank for referring you? _____

_____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Their Name: _____Relation: _____

Work Ph #:_____Home Ph #: _____

4 Child's Dental Insurance

Primary Dental Insurance

Insured's Name: _____
Last First Initial

Birthdate of Insured:_____/_____/_____
Month Day Year

SIN # _____Relation to child: _____

Insurance Co. Name: _____

Group # _____

Certificate #: _____

Coverage Basic%_____ Major %_____ Yearly Max: _____

What restrictions do you have on your dental insurance?

_____

_____

eg. How many units of scaling are covered?
How often does your plan cover dental examination?

Secondary Dental Insurance

Insured's Name: _____
Last First Initial

Birthdate of Insured:_____/_____/_____
Month Day Year

SIN # _____Relation to child: _____

Insurance Co. Name: _____

Group # _____

Certificate #: _____

Coverage Basic%_____ Major %_____ Yearly Max: _____

What restrictions do you have on your dental insurance?

_____

_____

eg. How many units of scaling are covered?
How often does your plan cover dental examination?
Who will be responsible for your Account: ❑ Mother ❑ Father

If another person please complete the following:

Their name: _____

SIN # _____Relation to child: _____

Billing Address: _____

Work Phone #: _____ Ext: ____ Home #: _____

Employer: _____

Who is responsible for making appointments?

Their name: _____

SIN # _____Relation to child: _____

Work Phone #: _____ Ext: ____ Home #: _____

Thank you for filling out this form completely. It enables us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help!
Our office is committed to exceeding the standards of infection control mandated by OHSA, the CDA and the ADA.

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Does your child have any dental problems that you are aware of? ❑ Yes ❑ No If Yes, please explain: _____

Has your child been to the dentist before? ❑ Yes ❑ No If Yes, approximate date of last visit: _____
Name of previous dentist: _____

Has your child ever had a serious/difficult problem associated with dental work? ❑ Yes ❑ No If Yes, please explain: _____

Does your child have a finger or thumb habit? ❑ Yes ❑ No If Yes, how long: _____

Has your child ever had an injury to their face or jaw? ❑ Yes ❑ No If Yes, please explain: _____

Are you happy with the appearance of your child's teeth? ❑ Yes ❑ No If No, please explain: _____

Does your child have a personal physician? ❑ Yes ❑ No Physician's Name: _____ Phone #: _____
Is your child under the care of a Physician? ❑ Yes ❑ No Please describe your child's current physical health
❑ Good ❑ Fair ❑ Poor

Is your child taking any prescription or over the counter drugs? ❑ Yes ❑ No If yes, please list each one: _____

Is your child allergic or have you ever noticed a reaction to any of the following?

Penicillin (antibiotics)	Y N	_____			
Latex (dental gloves)	Y N	_____	Erythromycin (antibiotics)	Y N	_____
Local Anesthetics (dental freezing)	Y N	_____	Aspirin	Y N	_____
Nitrous Oxide (dental gas)	Y N	_____	Iodine	Y N	_____

Does your child have any other allergies? ❑ Yes ❑ No If Yes, please list: _____

Has your child had, or do they have any of the following diseases or medical problems? Please circle the appropriate response.

Heart Murmur	Y N	_____	Tuberculosis	Y N	_____
Heart Problems of any kind	Y N	_____	Radiation Treatment	Y N	_____
Diabetes	Y N	_____	Asthma	Y N	_____
Rheumatic or Scarlet Fever	Y N	_____	Anaemia	Y N	_____
Cancer/Chemotherapy	Y N	_____	Bruise Easily	Y N	_____
Hepatitis A/B	Y N	_____	Sinus Problems	Y N	_____
HIV+/AIDS/A.R.C.	Y N	_____	Kidney Liver Problems	Y N	_____
Heamophilia/Abnormal Bleeding	Y N	_____	Epilepsy or Seizures	Y N	_____
Hearing Impairment	Y N	_____	Any operations	Y N	_____
Any stays in a hospital	Y N	_____	Handicaps/Disabilities	Y N	_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian _____ Date _____

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Doctors Comments: DATE:

_____

_____

Dr. David B. Sawka & Associates

WELCOME TO OUR PRACTICE!

Thank you for selecting us as your personal dental team. We are very proud of our knowledgeable, well trained, and caring dental team. You will find us dedicated to maintaining optimum oral health.

Please take time to familiarize yourself with some of our office procedures and policies.

- No charge will be made for rescheduling an appointment, providing 24 hours working notice is given, otherwise a charge may be incurred. Once an appointment has been made, please remember this time has been reserved specifically for you.
- Dental insurance is a contract between you and your insurance company. As a courtesy, we will prepare and submit dental claims on your behalf. Our office does not accept insurance assignment of benefits. We require full payment of services at each visit, and your insurance will send the payment to you directly. Please be aware that it is your responsibility to know your dental plan and any changes that may occur from time to time.
- All accounts are to be paid in full at each appointment, unless written financial arrangements are signed in advance of your treatment. Please discuss payment options and fees with one of our staff, and they would be pleased to work with you to make the required arrangements. For such extended financial arrangements we require an initial deposit before treatment is started and post dated cheque, Visa/MasterCard payments to be left for the balance.
- For your convenience, we accept the following forms of payment: cash, Visa, MasterCard, direct payment (Interac), cheque, post dated Visa, MasterCard, or cheque.

YOUR FINANCIAL CONSENT

The patient/or guardian agrees to be fully responsible for total payment of procedures performed in this office, including any treatment not a covered benefit of any dental insurance the patient may have.

I certify I have read and understand the above.

Date:_____

Patient/Guardian Signature:

_____

FINANCE

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option that you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

❑ Cash ❑ Debit

❑ Credit Card ❑ Visa ❑ MasterCard

Card#_____

Expiry Date _____ Signature_____

#10 - 402 RAILWAY STREET COCHRANE, AB T4C 2B6 (403) 932-3031

Dr. David Sawka

Dental Office Personal Information Consent Form

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 described 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 practice.

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:

- 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 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.

I consent to the collection, use and disclosure of my personal information as set out above.

_____	_____	_____
D*ate*	*Print name*	*Signature*