MAR ORTHODONTICS | CHILD PATIENT INFORMATION

The following information is required to provide Mar Orthodontics a better understanding of your orthodontic needs and your medical history.
Please complete both pages of this form and bring it with you to your exam. You can also email the form prior to your appointment to info@marorthodontics.ca.

Last Name: **First Name:** **Preferred Name:**

Address: **City/Postal Code:**

Home Phone: **Grade:** **School Name:**

Patient resides with: ❑ Both Parents ❑ Mother ❑ Father ❑ Other **Sex:** ❑ Male ❑ Female **Age:** **Birthdate:** MONTH/DAY/YEAR

Parent's Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Common Law

Please describe the Orthodontic problem in your own words:

Who noticed the Orthodontic problem?
❑ Parent ❑ Patient ❑ Dentist ❑ Other

Do you know a patient in our practice currently?
❑ NO ❑ YES

Who may we thank for referring you?

PARENT/GUARDIAN ORTHODONTICS INSURANCE INFORMATION

Do you have Treaty Status? ❑ No ❑ Yes # _____ Or any other government coverage? ❑ No ❑ Yes # _____

Who has orthodontic coverage? ❑ Father ❑ Mother ❑ Step Father ❑ Step Mother ❑ Guardian ❑ Other (Please Specify):

PLEASE NOTE: Having GENERAL DENTAL coverage does not mean you have ORTHODONTIC coverage

FATHER/GUARDIAN GENERAL INFORMATION

Father's/Guardian's Name:

Address:

City: Postal Code:

Home Ph: Cell Ph:

Email Address:

Birthdate Father/Guardian (MONTH/DAY/YEAR):

Relationship to child above:

FATHER'S/GUARDIAN'S EMPLOYMENT INFORMATION

Employer's Name:

Employer's Address:

Work Ph: Cell Ph:

Father's/Guardian's Occupation:

FATHER'S/GUARDIAN'S ORTHODONTIC INSURANCE INFORMATION

Insurance Company Name:

Group/Policy/Plan Number:

Certification/ID Number:

MOTHER/GUARDIAN GENERAL INFORMATION

Mother's/Guardian's Name:

Address:

City: Postal Code:

Home Ph: Cell Ph:

Email Address:

Birthdate Mother/Guardian (MONTH/DAY/YEAR):

Relationship to child above:

MOTHER'S/GUARDIAN'S EMPLOYMENT INFORMATION

Employer's Name:

Employer's Address:

Work Ph: Cell Ph:

Mother's/Guardian's Occupation:

MOTHER'S/GUARDIAN'S ORTHODONTIC INSURANCE INFORMATION

Insurance Company Name:

Group/Policy/Plan Number:

Certification/ID Number:

Insurance Information

A dental insurance policy is a contract between the insured and the insurance company. The policy of the Orthodontic Association is to charge the patient directly for all services rendered. To assist those of you with insurance coverage, Mar Orthodontics will complete their part of a standard claim form, you will complete your part and send to your insurance company for reimbursement. After your consultation, Mar Orthodontics will forward a pre-authorization to your insurance company for approval to proceed with treatment. When treatment is started our patient contract coordinator will explain the payment/reimbursement process. If you have any further questions regarding insurance, please speak with our patient contract coordinator.

Dr. Ly T. Mar, D.M.D., Cert. G.P.R., Cert. Ortho., M.Sc., F.R.C.D.(C)
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www.marorthodontics.ca

MAR ORTHODONTICS | MEDICAL HISTORY FORM

Physician's Name: **Address:** **Phone:**

Has your child experienced any health problems? ❑ NO ❑ YES
Explain:

Any major change in your child's health recently? ❑ NO ❑ YES
Explain:

Is your child currently under a Physician's care? ❑ NO ❑ YES
Explain:

Is your child currently taking any medications? ❑ NO ❑ YES
Explain:

Is your child allergic to any medications/latex? ❑ NO ❑ YES
Explain:

Has your child received a blood transfusion? ❑ NO ❑ YES
Explain:

Has your child had their tonsils or adenoids removed? ❑ NO ❑ YES
Explain:

Has your child been in a risk group for AIDS/HIV positive? ❑ NO ❑ YES
Explain:

Is your child currently in good health? ❑ NO ❑ YES
Explain:

Is your child experiencing or have they experienced any of these symptoms?

a. Fever ❑ NO ❑ YES

b. Sore Throat ❑ NO ❑ YES

c. Joint Pain ❑ NO ❑ YES

d. Muscle Aches ❑ NO ❑ YES

e. Sever Exhaustion ❑ NO ❑ YES

f. Sudden onset of **new** cough or **change** in existing cough ❑ NO ❑ YES

Has your child been out of Canada in the last six months? ❑ NO ❑ YES

Where?

When?

Women Only: Is your child pregnant or nursing? ❑ NO ❑ YES
It is important to notify staff if there is a possibility of pregnancy

Please check if your child has had any of the following conditions:

- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Rheumatic Fever
- ❑ Endocrine Disorders
- ❑ Prolonged Bleeding
- ❑ Anemia, Blood Disorder
- ❑ Developmental Disorder
- ❑ Hives/Rash
- ❑ Hepatitis, Liver Disorders
- ❑ Diabetes
- ❑ Kidney Disease
- ❑ Tuberculosis
- ❑ Bronchitis
- ❑ Asthma
- ❑ Epilepsy
- ❑ Fainting
- ❑ Emotional Problems
- ❑ Nervous/Anxious
- ❑ Cancer
- ❑ Bone Disorder
- ❑ Growth Disorders
- ❑ Herpes (Fever blisters)
- ❑ Tonsillitis
- ❑ Respiratory Allergies

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MAR ORTHODONTICS | DENTAL HISTORY FORM

Dentist's Name: _____ **Address:** _____ **Phone:** _____

Dental Specialist's Name: _____ **Address:** _____ **Phone:** _____

Frequency of dental check-ups: ❑ Twice a year ❑ Once a year ❑ Only if problems exist Date of last visit : _____

Frequency of cleanings: ❑ Twice a year ❑ Once a year Date of last visit : _____

Is there any unfinished care to be completed with your child's dentist? ❑ NO ❑ YES
Explain:

Is your child frightened about dental treatment? ❑ NO ❑ YES
Explain:

Has your child ever had an unpleasant dental experience in a dental office? ❑ NO ❑ YES
Explain:

Has your child had any face or dental injuries? ❑ NO ❑ YES
Explain:

Has your child had any teeth removed? (either primary (baby) or permanent)? ❑ NO ❑ YES
Explain:

Have you consulted an orthodontist previously for your child? ❑ NO ❑ YES
Explain:

Has your child had any previous orthodontic treatment? ❑ NO ❑ YES
Explain:

Does your child have a history of thumb or finger sucking? ❑ NO ❑ YES
Explain:

Is your child presently wearing an appliance? ❑ NO ❑ YES
Explain:

Please check if your child has a history of:

❑ Speech problems (If so, which sounds)

❑ Clenching teeth

❑ Grinding teeth

❑ Muscular soreness around head & neck

❑ Headaches (more than normal)

❑ Jaw joint soreness

❑ Jaw joint clicking

❑ Mouth breathing: Awake or Asleep

❑ Jaw joint popping

❑ Ringing in the ears

Is there any other condition or problem that you think we should know about?

Signature of: _____
(Parent or Legal Guardian)

Print Name: _____ **Date Completed:** _____
(Parent or Legal Guardian) *(by Parent or Legal Guardian)*

Signature of: _____ **Date Reviewed:** _____
(Orthodontist) *(by Orthodontist)*

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MAR ORTHODONTICS | 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, cellular 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 patient 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 for 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 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 for 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 or dental specialists if the patient, with their consent, had been referred by us to the other dentists or dental specialists for treatment.
- To other dentists or 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 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 staff as part of its regulatory activities in the public interest.

PLEASE REVIEW, COMPLETE AND RETURN TO THIS OFFICE.

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

Adult Patient/Parent/Guardian Signature: _____

Print Name: _____ **Date Completed:** _____

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