

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	MOTHER/GUARDIAN GENERAL INFORMATION
Father's/Guardian's Name: _____	Mother's/Guardian's Name: _____
Address: _____	Address: _____
City: _____ Postal Code: _____	City: _____ Postal Code: _____
Home Ph: _____ Cell Ph: _____	Home Ph: _____ Cell Ph: _____
Email Address: _____	Email Address: _____
Birthdate Father/Guardian (MONTH/DAY/YEAR): _____	Birthdate Mother/Guardian (MONTH/DAY/YEAR): _____
Relationship to child above: _____	Relationship to child above: _____
FATHER'S/GUARDIAN'S EMPLOYMENT INFORMATION	MOTHER'S/GUARDIAN'S EMPLOYMENT INFORMATION
Employer's Name: _____	Employer's Name: _____
Employer's Address: _____	Employer's Address: _____
Work Ph: _____ Cell Ph: _____	Work Ph: _____ Cell Ph: _____
Father's/Guardian's Occupation: _____	Mother's/Guardian's Occupation: _____
FATHER'S/GUARDIAN'S ORTHODONTIC INSURANCE INFORMATION	MOTHER'S/GUARDIAN'S ORTHODONTIC INSURANCE INFORMATION
Insurance Company Name: _____	Insurance Company Name: _____
Group/Policy/Plan Number: _____	Group/Policy/Plan Number: _____
Certification/ID 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

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. Severe Exhaustion NO YES

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

 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

 Liver Disorders or Hepatitis __ A __ B __ C

 Diabetes __Type 1 __Type 2

 Kidney Disease

 Tuberculosis

 Bronchitis

 Asthma

 Epilepsy

 Fainting

 Emotional Problems

 Anxiety Disorders

 Cancer

 Bone Disorders

 Growth Disorders

 Herpes (Fever blisters)

 Tonsillitis

 Respiratory Allergies

Please provide any important health information not mentioned above.

St. Albert

 Suite 128, 2 Hebert Road P 780 459 3580
 St. Albert, AB T8N 5T8 F 780 460 2985

Sherwood Park

 Suite 125, 501 Bethel Drive P 780 449 4596
 Sherwood Park, AB T8H 0N2 F 780 417 0350

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?

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Name: _____

(Please Print)

Date Completed: _____

(by Parent/Legal Guardian)

Signature of: _____

(Orthodontist)

Date Reviewed: _____

(by Orthodontist)

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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.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Name: _____ **Date Completed:** _____
(Please Print)