CONNORS FAMILY DENTISTRY – CONFIDENTIAL CHILD REGISTRATION

Child's Information Date**:**_____

Child's Name:_____

Nickname:_____ Birthdate:_____

Parent/Guardian Home Ph ( )_____Work Ph (___)_____

Cell Ph(___) _____Email:_____

Address:_____

City: _____Postal Code:_____

Family Physician:_____ Phone#:(___)_____

Medical Specialist (if under care):_____

Your Child's Dental/Medical History

When did your child last receive dental treatment?_____

For what service (cleaning, emergency, filling etc):_____

Date of last dental x-rays:_____

Any dental concerns:_____

Do they brush daily? □Yes/□No

Is dental floss used? □Yes/□No

Do they take any fluoride supplementation? □Yes/□No

Has your child had any unfavourable experiences in a dental/medical office? □Yes/□No

Does your child have any of the following habits, which might affect the teeth or mouth?

Mouth Breathing	□Yes/□No	Tongue Thrusts	□Yes/□No
Teeth Grinding	□Yes/□No	Sucks thumb/ fingers	□Yes/□No
Bites fingernails	□Yes/□No	Pacifier	□Yes/□No

Is your child currently under the care of a physician? Explain:_____

_____

Has your child had/have any problems with the following?

Measles	□Yes/□No	Cold Sores	□Yes/□No	Monoucleosis	□Yes/□No
Canker sores	□Yes/□No	Chicken Pox	□Yes/□No	Thrush	□Yes/□No
Mumps	□Yes/□No	Hepatitis	□Yes/□No	Heart problems	□Yes/□No
Strep Throat	□Yes/□No	Tonsillitis	□Yes/□No	Anemia	□Yes/□No
Diabetes	□Yes/□No	Asthma	□Yes/□No	Cancer	□Yes/□No
Fainting	□Yes/□No	Sickle Cell	□Yes/□No	Hearing	□Yes/□No
Kidney	□Yes/□No	Liver	□Yes/□No	German Measles	□Yes/□No
Cerebral Palsy	□Yes/□No	Thyroid	□Yes/□No	Epilepsy/Seizures	□Yes/□No
Ear infections	□Yes/□No	HIV/AIDS	□Yes/□No	Bleeding Disorders	□Yes/□No
Tobacco Use	□Yes/□No	Other:_____			

Allergies □Yes/□No If yes, specify: _____

(ie: penicillin, latex, medications, foods or products)

Has your child ever been seriously sick, hospitalized, or had surgery? □Yes/□No

Where, When, Why?_____

Is your child presently taking any medications (prescription or over the counter)?□Yes/□No

Please list:_____

Has your child had any excessive bleeding when cut? □Yes/□No

Has a cardiologist or family doctor informed you of your child's need to be placed on a prophylactic antibiotic coverage prior to any dental procedures? □Yes/□No

Is your child pregnant? □Yes/□No

Does your child have any physical, mental, or emotional disabilities? □Yes/□No

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How did you hear about our office?_____

_____ _____
Reviewed by Dr. Connors Date

CONNORS FAMILY DENTISTRY

Authorization & Release

I, the undersigned, certify that I have read, understood, informed myself, and answered the above questionnaire to the best of my knowledge. I hereby promise to inform you of any change in the state of my child's health. I understand that providing incorrect health information can be dangerous to my child's health. I authorize Dr. Connors/Connors Family Dentistry to release any information including the diagnosis and third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all records of any treatment/examination rendered to me or my child during the period of such dental care services rendered on my behalf of my dependents. I authorize Dr. Connors/Connors Family Dentistry to submit my insurance claims electronically on my behalf.

Signature:_____ Date:_____

Relationship to child:_____

Authorizations for Treatment

I, authorize Dr. Connors & staff at Connors Family Dentistry to perform diagnostic procedures including an examination, x-rays, photographs, models, cleaning & fluoride treatments when necessary, as the standard of care to properly diagnose and record any and all dental conditions (please cross out any treatment that you do not want performed).

Signature:_____ Date:_____

Relationship to Child:_____

Cancellation / Missed Appointment Policy

We understand that unplanned issues can come up and you may need to cancel an appointment.
We respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Dr. Connors and our practice hygienist want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancelation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not canceled within 24 hours.

As of January 1, 2021, there will be a fee of $50 assessed if we do not receive a call to cancel an appointment.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Signature:_____ Date:_____

Relationship to Child:_____

CONNORS FAMILY DENTISTRY-
COLLECTION, USE AND DISCLOSURE of PERSONAL HEALTH INFORMATION

Privacy of your personal health information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using, and disclosing your personal health information responsibly. We also try to be as open and transparent as possible about the way we handle your personal health information. It is important to us to provide this service to our patients.

In this office, Dr. Connors is the contact person for personal health information related matters.

All staff members who come in contact with your personal health information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information is collected about you and/or your child;
- We only share your information with your consent;
- Storage retention and destruction of your personal health information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

Do not hesitate to discuss our policies with me or any member of our staff. Please be assured that every staff person in our office is committed to ensuring that you and or your child receive the best quality dental care.

How Our Office Collects, Uses and Discloses Patients' Personal Health Information

Our office understands the importance of protecting your personal health information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose personal health information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality service
- To assess your health needs
- To provide health/dental care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide dental treatment, care and services in relationship to the oral and maxillofacial complex
- To communicate with other treating health care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists
- To allow us to maintain communication and contact with you to distribute health care information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- To complete and submit dental claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patient's charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of Regulated Health Professions Act
- To comply with agreements/undertakings entered into voluntarily by the member 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 permit potential purchasers, practice brokers, or advisors to evaluate the dental practice
- To allow potential purchasers, practice brokers, or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- To prepare materials for the Health Professions Appeal & Review Board (HPARB)
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirements

You may withdraw your consent for use or disclosure of your personal health information at any time.

PATIENT CONSENT

I have reviewed the above information that explains how our office will use my/my child's personal health information, and the steps our office is taking to protect my/my child's information.

I agree that Dr. Connors/Connors Family Dentistry can collect, use & disclose personal health information about myself and/or my child as set out above in the information about the office's privacy policies.

Signature:_____ Date:_____

Relationship to Child:_____

EMAIL AND TEXT COMMUNICATION CONSENT

In an effort to improve our communication with our patients, we would like to send some of our communications to you through emails and texts. To comply with the Canadian Anti-Spam Legislation (CASL) our dental office would like to have your express consent to communicate in this manner. If you decide to opt in and continue receiving emails and texts please know that you may opt out at any time and withdraw your consent.

Please sign below to give us permission or cross out any part you would like to decline:

Yes, I consent to our family receiving information via email and text from Dr. Connors/Connors Family Dentistry

Signature:_____ Date:_____

Relationship to Child:_____