DR. JOHN L. CHIASSON DENTISTRY (Youth)

REGISTRATION (YOUTH)

PATIENT

NAME: Last:__________________________ First:____________________ Initial:____ Date of Birth: (dd/mm/yr):____/____/___

Address: Street_______________________________ City:___________________________ Postal Code:________________

GUARDIAN'S NAME: Last:____________________________________ First:____

Phone Number: Cell:______________________ Home:_______________________ Email: ______________________________

Preferred Method of Contact: ___Phone ___ Text ___ Email Preferred time of Appointments: AM / PM / EVENING

Are you available for short notice appointments? ___ Yes __ No How did you hear about us?_______________________

EMERGENCY CONTACT: Name:____ Relationship to Child:______________

MEDICAL

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentialty. The doctor will review the questions. Please complete the form to the best of your ability.

FAMILY DOCTOR_ Name:____________________ Phone:_____________________ **Pharmacy** / Location: ________________

1. Is your child being treated for any medical condition at the present or within the past two years? ☐ Yes ☐ No
   If so, why?____
2. Does your child take any MEDICATION? ☐ Yes ☐ No
   If so, what?____
3. Has you child ever been hospitalized or had general anesthsia? ☐ Yes ☐ No
4. Has you ever been told that your child needs to take antibiotics before dental treatment? ☐ Yes ☐ No
5. Use controlled substance, cannibis or tabacco? ☐ Yes ☐ No

ALLERGIES...(check where applicable) ___Not Applicable ___Aspirin ___ Latex ___ Codeine ___ Anaesthic ___
Other (specify):____

Does your child have or had a history of any of the following? (Please check all that apply)

☐ AIDS or HIV Positive	☐ Chronic CougCold Sores /	☐ Hepatitis	☐ Mitral Valve Prolapse
☐ Anaphylaxis	☐ Blisters	☐ Heart SurgeryHeart	☐ Paget's Disease
☐ Anemia	☐ Cortisone Medication	☐ Murmer	☐ PsychiatricTreatment
☐ Angina Pectoris	☐ Diabetes	☐ Heart Attack / Failure	☐ Rashes / Hives
☐ Arteriosclerosis	☐ Drug Addiction	☐ Heart Pacemaker	☐ Radiation
☐ Asthma	☐ Excessive Bleeding	☐ Heart Trouble / Disease	☐ Rhumatic Fever
☐ Blood Transfusion	☐ Epilepsy / Seizure Disorder	☐ Hemophilia	☐ Sinus Trouble
☐ Breathing Problems	☐ Eye Impairment	☐ Hypoglycemia	☐ Stomach / Intestinal Disease
☐ Bruises Easily	☐ Fainting / Dizzy Spills	☐ Liver Disease	☐ Swelling of Limbs
☐ Cancer	☐ Frequent Headaches	☐ Kidney Problems	☐ Thyroid Disease
☐ Chemotherapy	☐ Hearing Impairment	☐ Malignant Hyperthermia	☐ Tuberculosis (TB)
			☐ Tumors / Growths / Ulcers

Has your child ever had any serious illness or disease not listed above? If yes, explain_______________________________
____

CONSENT FOR TREATMENT: I the undersigned have provided an accurate and complete medical and dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment for my child.

Guardian Signature________________________________ **Date**______________________

DENTAL HISTORY (YOUTH)

Please circle Yes or No, where applicable.

PATIENT: ___________________________________

Is this your child's first time to the dentist? ☐ Yes ☐ No

If yes, when was their last visit?______________

Dental visit: ___________ Hygiene Visit (Cleaning): ________ Dental x-rays: _________ Panoramic x-ray: ________

How many times a year does your child? Visit the dentist: _______________ Professional Cleaning: ____________

Is your child in pain ? Yes No If yes, please explain____

Has your child ever had any of the following treatments:

Dental work using freezing and or nitrous gas? ☐ Yes ☐ No

Dental work done while asleep or sedated while in a dental office or hospital? ☐ Yes ☐ No

Dental work done by a children's specialist / paedodonist? ☐ Yes ☐ No

Orthodontic Treatment (braces, retainers, appliance to teeth)? ☐ Yes ☐ No

How often does your child brush their teeth?in a day?______________________

What time(s) of the day does your child brush their teeth? AM PM

Do you help your child with brushing? ☐ Yes ☐ No

Does your child floss? ☐ Yes ☐ No , If yes how often?__________

Does your child:

Clench or grind their teeth? ☐ Yes ☐ No

Bite their fingernails? ☐ Yes ☐ No

Mouth breathe? ☐ Yes ☐ No

Chew on their lips or cheeks? ☐ Yes ☐ No

Suck their thumb / fingers? ☐ Yes ☐ No

Use a soother? ☐ Yes ☐ No

Have loose teeth? ☐ Yes ☐ No

Does your child eat a lot of sweets?

Does having dental treatments make your child nervous or uncomfortable? ☐ Yes ☐ No

Explain:____

Has your child ever had an upsetting experience in a dental office, or any complications during or following treament?

☐ Yes ☐ No

If yes, explain:____

Do you feel it is important for your child to have healthy baby (primary) teeth ? ☐ Yes ☐ No

The questions on this form have been accurately answered to the best of my knowledge.

Signature Of Patient, Parent Or Guardian ______________________________ **Date**____________________

DR. JOHN L. CHIASSON DENTISTRY

FINANCIAL AGREEMENT: CASH I PERSONAL HEALTH SPENDING ACCOUNTS (PHSP'S)

PATIENT:___________________________

As a condition of your or your child's treatment by this office, financial arrangements must be made prior to treatment; this includes dental emergencies . **PAYMENT IS DUE IN FULL AT TIME OF APPOINTMENT,** unless an alternative financial agreement has been made. We accept Cash, Visa, Mastercard, and Debit. Personal cheques will not be accepted. Please note that individuals who have a Personal Health Spending Account (PHSP) are required to submit dental claims to their insurance company directly.

CANCELLATION POLICY

We try our very best to offer you appointments that accomodate your schedule. This time is reserved just for you, and has been scheduled by you. In order to give you the best care possible and to be fair to all our patients and team, we ask that you make every effort to keep these appointments. If you are unable to keep your appointment, we ask that you provide us at least two business days notifice. Short Notice Cancellations and Missed Appointments may result in a $50 service fee. As a courtesy, automated text and email reminders are sent prior to appointments. We ask that you please confirm your appointment by responsding to the text / email, or calling the office. Your dental appointment is confirmed until we receive a verbal cancellation.

CONSENT

In accordance to the Federal and Provincial Privacy Legistation we will not disclose personal information and / or xray(s). However at times we do need to use the information for the following purposes: assess dental treatment,specialist referrals, appointment confirmations, account management, insurance purposes, and comply to requlatory reguirements.

I HAVE READ THE ABOVE CONDITIONS PERTAINING TO PAYMENT AND INSURANCE, CANCELLATIONS, AND AGREE TO THEIR CONTENT.

Patient / Responsible Party (Signature):_________________________ Date:__________________________

DR. JOHN L. CHIASSON DENTISTRY

DENTAL RECORDS RELEASE FORM

Patient Name to Transfer: ____________________

Date of Birth: ____________ Phone Number: ____________

Other Family Members to Transfer:

1. ____________ 2. ____________

3. ____________ 4. ____________

Previous Dentist or Dental Practice Name: ____________________

City: ____________________

Phone Nunber: ____________ Fax: ____________

E-Mail: ____________________

Please forward the following information that you have: x-rays, probing depth chart, charting and photographs to **Dr. John L. Chiasson**.

Last Complete Exam:

Last Recall / Polish / Flouride: Frequency:

Last Cleaning : Frequency:

Last BW's / Panoramic:

I hereby give you permission to release any and all dental records to **Dr. John L. Chiasson**

____________________ ____________

Patient's Signature (guardian if minor) Date

Dr. John L. Chiasson Dentistry

1470 Mosley Street, Unit #8

Wasaga Beach, ON L9Z2C2

705.352.1028 / contact@drjohnchiasson.com