Primary Care
pediatric dentistry

DR. JENNIFER HOWSON-JONES INC.
BSc, BDent, Dip. Ped, FRCD(C)
Pediatric Dental Specialist
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Office 604-427-1010 www.pcpediatricdentistry.com

WELCOME TO OUR OFFICE

We are dedicated to preventative dentistry and our aim is to help keep your child's teeth healthy for a lifetime. To help us treat your child, the following information is requested. Please print out this form, complete it, and bring it with you to our office on your first visit.

Patient Information:

NAME

SEX ☑ M ☐ F DATE OF BIRTH (MM/DD/YY)

ADDRESS:

CITY PROV POSTAL CODE

TEL (PRIMARY): HOW DID YOU HEAR ABOUT US?

WHO IS YOUR CHILD'S PHYSICIAN/PEDIATRICIAN? TEL

SIBLINGS? AGE? PATIENTS OF THIS OFFICE?

Parent or Guardian Information:

MOTHER/GUARDIAN

DOB (MM/DD/YY)

OCCUPATION

TEL (SECONDARY)

E-MAIL

FATHER/GUARDIAN

DOB (MM/DD/YY)

OCCUPATION

TEL (SECONDARY)

E-MAIL

Dental Insurance Information:

As your dental plan is a contract between you and your carrier, we encourage you to be completely familiar with the terms of your plan. We are a fee for service office and full payment is to be made at the time services are rendered.For your convenience, we accept Mastercard, Visa, debit, and cash. We do not accept cheques. Our staff will assist in processing your insurance claim forms and where applicable, file them electronically for you to ensure maximization of insurance benefits and rapid reimbursement.

PRIVATE INSURANCE ☐ YES ☐ NO NIHB/FIRST NATIONS ☐ YES ☐ NO

OTHER ☐ YES ☐ NO PHN: (CARE CARD) #

Dental History

Is your child currently experiencing any dental pain? ☐ YES ☐ NO

Is this your child's first visit to a dentist? ☐ YES ☐ NO If no, when was their last dental visit? _____

Has your child had an unfavorable dental/medical experience in the past? ☐ YES ☐ NO

Has your child ever injured his/her teeth or mouth? ☐ YES ☐ NO

If yes, please explain _____

Has your child ever taken Fluoride tablets or drops? ☐ YES ☐ NO

Do you brush your child's teeth? ☐ YES ☐ NO How many times a day? _____

Do you floss your child's teeth? ☐ YES ☐ NO

SEE OVER >

What type of toothpaste does your child use? _____

Does your child go to bed with a bottle? ☐ YES ☐ NO If yes, what's in the bottle? _____

What does your child drink during the day? _____

Does your child use a sippy cup? ☐ YES ☐ NO

Does your child suck fingers or thumb or have a similar habit? ☐ YES ☐ NO

Does your child participate in sports activities? ☐ YES ☐ NO

Is there additional information we should be aware of prior to providing dental care for your child? Please explain _____

_____

_____

Medical History

Has your child had any of the following?
(please check if yes)

- ☐ Heart disease
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Congenital heart defect
- ☐ Blood Disorders
- ☐ Blood transfusion
- ☐ Malignant hyperthermia
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ HIV/AIDS
- ☐ Infectious disease
- ☐ Bone or muscle problems
- ☐ Prosthetic joint
- ☐ Asthma
- ☐ Sleep apnea
- ☐ Recurrent headaches
- ☐ Fainting spells
- ☐ Seizures
- ☐ Cerebral palsy
- ☐ Cancer/tumors
- ☐ Diabetes
- ☐ Visual, hearing or sinus problems
- ☐ Anemia
- ☐ Skin problems (eg. eczema)
- ☐ Stomach ulcers
- ☐ Speech problems
- ☐ Cleft lip/palate
- ☐ Endocrine/growth problems
- ☐ Emotional/Social problems
- ☐ Autism
- ☐ Behavioral problems
- ☐ Other

1. Has your child ever been hospitalized or had an operation?
☐ YES ☐ NO If yes, please explain _____
_____

2. Is your child being treated for any medical condition at the present time or within the past year? ☐ YES ☐ NO
If yes, please explain _____
_____

3. Has you child ever had general anesthesia before?
☐ YES ☐ NO If yes, when? _____

4. Are your child's immunizations up-to-date? ☐ YES ☐ NO

5. Were there any complications surrounding the pregnancy or birth of your child? ☐ YES ☐ NO If yes, please explain _____
_____

6. Has your child ever had prolonged bleeding following a tooth extraction or minor injury? ☐ YES ☐ NO

7. Is your child taking any medication, non-prescription drugs or herbal supplements of any kind? ☐ YES ☐ NO
If yes, please list _____
_____

8. Is your child allergic to any medication (penicillin, pain killers, sulfa drugs, etc.)? ☐ YES ☐ NO
Please name any allergies that you are aware of:
_____
_____

I, the undersigned, verify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my physician being contacted if necessary to obtain information that is required for my child's dental care. I authorize the dentist to perform the diagnostic procedures that may be required to determine the necessary treatment and assume financial responsibility for dental services rendered for my child.

Signature of Parent or Legal Guardian | Relationship to patient | Date (MM/DD/YY)

Reviewed by Dentist | Date (MM/DD/YY)

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PATIENT PRIVACY CONSENT FORM

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

In this office, Dr. Jennifer Howson-Jones acts as the Privacy Information Officer. All staff members who come in contact with your personal 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. Do not hesitate to discuss our policies with any member of our office staff.

At Primary Care Pediatric Dentistry, we ensure that only necessary information is collected about you; we only share your information with your consent; storage, retention and destruction of your personal 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 British Columbia,and the law.

We will collect, use and disclose information about you for the following purposes:

- ❑ to deliver safe and efficient patient care
- ❑ to ensure continuous high quality service
- ❑ to assess your health needs
- ❑ to advise you of treatment options
- ❑ to communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists
- ❑ to enable us to contact and maintain communication with you, to book and confirm appointments
- ❑ to allow us to efficiently follow-up on your treatment and on-going care
- ❑ to facilitate the billing process
- ❑ to complete and submit dental claims on your behalf
- ❑ to comply with legal and regulatory requirements according to the provisions of the ***Regulated Health Professions Act*** and also for other regulatory and monitoring purposes
- ❑ to present individual cases for teaching and demonstrating purposes on an anonymous basis

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent.

By signing the consent section of this Patient Privacy Consent Form (below), you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

PATIENT PRIVACY CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that Dr. Jennifer Howson-Jones Inc. can collect, use and disclose personal information about _____ as set out above in the information about the office's privacy policies.
(patient's name)

Signature of Parent or Legal Guardian | Relationship to patient | Date (MM/DD/YY)

Signature of Witness | Date (MM/DD/YY)

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