DR. JOHN L. CHIASSON DENTISTRY (Youth)

PATIENT INFORMATION

Date:_____

Name:_____ Preferred Name:_____
first last initial

Date of Birth: ____/_____/_____ Sex: M / F Status: Single / Married / Child / Other
day / month / year

If Minor Guardian's Name:_____
first last initial

Address: _____ **Please provide two contact phone numbers or a phone number and an e-mail**
Street City Province Postal

Home Phone: (____)_____ Cell: (____)_____ Business: (___)_____ ext_____

E-mail:_____ **Preferred method of communication** : home / work / cell / e-mail

Emergency Contact Name:_____ Phone Number:_____

Are you available for short notice appointments: Yes / No How did you hear about us?_____

FINANCIAL INFORMATION

Do you have dental insurance? Yes / No

Policy Holder's Name:_____ Date of Birth:_____/_____/_____
first last initial day / month / year

Relationship to patient? Spouse / Child / Partner / Other Phone #__(_____)_____

Group / Plan#:_____ ID#_____ Percent of coverage (i.e. 80%) : _____

Employer's Name:_____ Insurance Company:_____

SECONDARY INSURANCE (patients with secondary insurance are responsible for submitting claims themselves)

Policy Holder's Name:_____ Date of Birth:_____/_____/_____
first last initial day / month / year

Relationship to patient? Spouse / Child / Partner / Other Phone #_(___)_____

Group / Plan#:_____ ID# _____ Percent of coverage (i.e. 80%) :_____

Employer's Name:_____ Insurance Company:_____

OFFICE PAYMENT POLICY

PAYMENT IS DUE IN FULL AT TIME OF APPOINTMENT. We accept Cash, Visa, Mastercard, and Debit _____ (initial). No personal cheques will be accepted. Our office is equipped to submit insurance claims electronically, with correct information. Insurance claims are electronically submitted at time of appointment. **Direct Billing** is available, some restrictions apply.

CANCELLATION POLICY: Your appointment time has been reserved especially for you. If you are unable to keep your appointment **we require 2 full business days notice**. A charge will be applied for missed or cancelled appointments. _____ (initial)

I understand and agree to the above to the policies listed above. _____ _____
responsible party (print) signature

Patient / Responsible Party / Guardian

I authorize release, to my dental benefits plan admin & the CDA, the details of claims submitted electronically.

_____ _____ _____
signature date witness

MEDICAL HISTORY (16 and Under)

Please circle YES (Y) or NO (N) to, where applicable

PATIENT:_____ Physician's Name: _____

Are you currently being treated for any medical condition? Yes No If yes, please explain_____

_____

Have you been hospitalized in the past 2 years? Yes No If yes, please explain_____

Do you take any medications? Yes No List : _____

_____

Do you require a pre-medication? Yes No If yes, please explain_____

Do you have an artificial joint? Yes No If yes, which_____

Do you use tobacco? Cannabis? Yes No

Do you use controlled substances? Yes No

WOMEN Are you pregnant or trying to get pregnant? Yes No If yes, how many weeks_____

Do you breastfeed? Yes No Do you use oral contraception Yes No

ALLERGIES ....Are you allergic to Aspirin Latex Codeine Anaesthetic Other (specify) _____

_____

Indicate which of the following you have had any of the following (please specify)

AIDS or HIV Positive	Y N	Developmentally Disabled		Liver Disease	Y N
Alzheimer's	Y N	Diabetes	Y N	Low Blood Pressure	Y N
Anaphylaxis	Y N	Drug Addiction	Y N	Kidney Problems	Y N
Anemia	Y N	Excessive Bleeding	Y N	Malignant Hyperthermia	Y N
Angina Pectoris	Y N	Emphysema	Y N	Mitral Valve Prolapse	Y N
Arthritis / Gout	Y N	Epilepsy or Seizure Disorder	Y N	Osteoporosis	Y N
Artificiality Heart Valve	Y N	Fainting / Dizzy Spells	Y N	Paget's Disease	Y N
Artificial Joints (i.e. hip or knee)	Y N	Frequent Headaches	Y N	Pain in Jaw Joints Psychiatric	Y N
Arteriosclerosis	Y N	Genital Herpes	Y N	Treatment Rashes or Hives	Y N
Asthma	Y N	Glaucoma	Y N	Radiation Treatment	Y N
Blood Transfusion	Y N	Hepatitis A	Y N	Renal Dialysis Rheumatism	Y N
Breathing Problems	Y N	Hepatitis B or C	Y N	Rheumatic Fever	Y N
Bruises Easily	Y N	Hay Fever	Y N	Sinus Trouble	Y N
Cancer	Y N	Heart Murmur	Y N	Stomach / Intestinal Disease	Y N
Chemotherapy	Y N	Heart Attack / Failure	Y N	Swelling of Limbs	Y N
Chronic Cough	Y N	Heart Pacemaker	Y N	Thyroid Disease	Y N
Cold Sores or Blisters	Y N	Heart Surgery	Y N	Tuberculosis (TB)	Y N
Congenital Heart Disorder	Y N	Hemophilia	Y N	Tumors or Growths	Y N
Cortisone Medicine	Y N	Heart Trouble / Disease	Y N		Y N
Dental or TMJ Implants	Y N	Hypoglycemia	Y N	Ulcers	Y N
		High Blood Pressure	Y N		

Have you ever had any serious illness not listed above? Yes No If yes, explain_____

_____

To my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health). It is my responsibility to inform the dental office of any changes in medical status.

Signature Of Patient, Parent Or Guardian _____ **Date**_____

CONSENT FOR TREATMENT....I, the undersigned, certify that I have provided an accurate and complete personal and medical / dental history understand... I understand that information provided from or to the patient's health or medical doctor.... I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment.

Signature Of Patient, Parent Or Guardian _____ **Date**_____

DENTAL HISTORY (YOUTH)

Please circle YES or No, where applicable.

PATIENT:_____

Last dental visit: _____ Last Professional Cleaning: _____ Last dental x-rays: _____

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

Is your child in pain ? Yes No

Have 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, in a dental office or hospital?	Yes No
Dental work by a children's specialist / paedodonist?	Yes No
Teeth removed by a dentist specialist?	Yes No
OrthodonticTreatment (braces, retainers, appliance to teeth)?	Yes No

How often do you brush your teeth? _____

Do you help your child with brushing? Yes No

Does your child floss? Yes No , 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
Loose teeth?	Yes No

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

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

Yes No

Explain:_____

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

To my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health). It is my responsibility to inform the dental office of any changes in medical status. CHILDREN (16 and under) must be accompanied by an adult.

Signature Of Patient, Parent Or Guardian _____ **Date**_____

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: _____

Address: _____

City: _____

Phone Number: _____

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

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

_____ _____

Patient's Signature (guardian if minor) Date

If records are digital, please e-mail to: **contact@drjohnchiasson.com**

Or mail to:

Dr. John L. Chiasson Dentistry
1470 Mosley Street, Unit #8
Wasaga Beach, ON L9Z2C2

Dr. John L. Chiasson Dentistry

1470 Mosley Street, Unit 8, Wasaga Beach ON, L9Z2C2

COVID-19 Pandemic Emergency Dental Risk

Please read the patient acknowledgement below, and initial or sign in all areas indicated.

I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. I understand that the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. For this reason, I understand that the federal and provincial authorities have recommended that Ontarians stay home and avoid close contact with other people when at all possible. _____ (initial)

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters (six (6) feet) and I recognize it is not possible to maintain this distance while receiving dental treatment. _____ (initial)

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one way that the novel coronavirus can spread. I understand that the ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. _____ (initial)

I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in the dental office. _____ (initial)

I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: (i) fever, (ii) new or worsening cough, (iii) sore throat, (iv) runny nose or (v) headache. _____ (initial)

If I received COVID-19 test results in the past three (3) months, the last results I received were negative. _____ (initial) If applicable, approximate date of test: _____

I confirm that I am not waiting for the results of a test for COVID-19. _____ (initial)

I confirm that this is not currently a period during which public health authorities required I self-isolate for 14 days. _____ (initial)

I verify the information I have provided on this form is truthful and complete. I knowingly and willingly consent to have emergency surgical/dental treatment completed during the COVID-19 pandemic.

SIGNATURE OF PATIENT _____ Date _____

Adapted from ODA