Millennium Dental
403 236-4443

- Dr. Munira Jivraj
- Dr. Moez Lakhani
- Dr. Salima Shariff
- Dr. Veeta Maharaj

Personal Information - Child

Patients Name: _____ Today's date: _____

Parent/Guardian: _____ Relationship to Patient: _____

Address: _____ Postal Code: _____

Phone Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: M F Email Address: _____

Emergency Contact: _____ Phone: _____

Physician: _____ Phone: _____

Previous Dentist: _____ Phone: _____

How did you hear about our clinic? _____

Medical History

Has your child seen a doctor, in the past year, if yes, for what reason?_____

Does your child have any drug allergies that you are aware of? YES NO Please List:_____

Does your child have a Latex Allergy? YES NO

Has your child ever taken (please circle): Penicillin Erythromycin Sulfa Drugs Tetracycline Codeine

Is your child presently taking any Medications? YES NO Please List: _____

Has your child ever been treated for, or had any indication of:

- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Asthma
- ☐ Bell's Palsy
- ☐ Blood Disorders
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Clotting/Bleeding Problems
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Hepatitis A or B
- ☐ Jaundice
- ☐ Mental/Nervous disorders
- ☐ Migraines/headaches
- ☐ Rheumatic Fever
- ☐ Sinus problems
- ☐ Snoring
- ☐ Surgery

Appointment Policy:

We would like to ask for a minimum of ***2 BUSINESS DAYS NOTICE*** if for any reason you will be unable to keep a scheduled appointment. This consideration will allow us to accommodate those patients that may be waiting for an appointment.

For your convenience, we will continue to call or email you prior to your appointment to remind you and receive confirmation for your visit.

I, _____ have read & understand the above policy. Date: _____ Signature:_____

DENTAL HISTORY

Last complete Dental Exam? _____ Were X-rays Taken **Y** **N** Has your child ever had their teeth cleaned or polished? **Y** **N**

Has your child ever had freezing? **Y** **N** Were there any complications? **Y** **N** EXPLAIN: _____

Do you feel your child's daily dental care is adequate? **Y** **N** EXPLAIN: _____

How many times per week does your child brush? _____ How many times do you supervise your child brushing? _____

Does your child suck his/her thumb or fingers? **Y** **N** IF YES HOW OFTEN? _____

Has your child ever had a bad experience at the dentist? **Y** **N** IF YES EXPLAIN? _____

How comfortable would you say your child is with today's visit? 1-APPREHENSIVE 10- EXCITED _____

Do you have any concerns with your child's teeth? **Y** **N** _____

If your child experiencing any discomfort or pain in his/her teeth? **Y** **N** _____

Is there anything you would like to make us aware of that has not been covered on this form? YES NO

(PLEASE LIST): _____

PERMISSION TO TREAT/RELEASE OF INFORMATION/PRIVACY

This is to certify that I, the undersigned, consent to the performance of dental treatment agreed to be necessary or advisable by the Dentist. I will assume full responsibility for fees associated with treatment. I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same. I am aware the office has a Privacy Policy which I can view at any time.

Date: _____ Signature of Patient/Parent/Guardian: _____

DENTAL INSURANCE

We are more than happy to help you with your insurance claims. Payment in full is required at the time of service. Whenever possible, we will electronically send your insurance claims which will speed up the process for you and you should receive your insurance reimbursement within a few short days. **NOTE:** *Policy holder whose birthday falls first in the year is the "Primary Policy" holder*

Primary Policy

Name:_____ DOB: _____ Provider:_____ Group #:_____ I.D #_____

Secondary Policy

Name:_____ DOB: _____ Provider:_____ Group #:_____ I.D #_____