Smile Buddy
Children's Dentistry

Suite 112 – 3883 Front Street SE
Calgary, AB T3M 2J6

403-250-5830 • smilebuddy.ca

Welcome to

Smile Buddy Children's Dentistry

We look forward to seeing you at your scheduled appointment.
If you haven't been to our Seton location before, we are located across the street from the **South Health Campus Hospital, Suite 112-3883 Front Street SE**.

You can park on the street out front or there is parking in the rear of the building.
It is a paid parking area, please **DO NOT pay**; come in with your licence plate number and we will validate your parking for you at each visit.

Attached are your new patient intake forms, please fill out online and send back to our office prior to your scheduled visit.

If you have any questions prior to your appointment, please do not hesitate to contact our office.

Our team looks forward to meeting you!

Patient Information

Let us know if you have any questions

Patient 1

First Name: _____

Last Name: _____

Birth date (M/D/Y) _____ M ◯ F ◯

Alberta Health Care# _____

Patient 2

First Name: _____

Last Name: _____

Birth date (M/D/Y) _____ M ◯ F ◯

Alberta Health Care# _____

Parent/Guardian:

First Name: _____ Last Name: _____ Birthdate(M/D/Y):_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Cell Phone: _____ Other Phone: _____

Email Address: _____

What kind of appointment reminders would you like to receive? Leave blank for no reminders.

☐ Text
☐ Email

Secondary Guardian (if applicable):

First Name: _____ Last Name: _____ Birthdate(M/D/Y): _____

Same Address as Above: ◯

Address: _____

City: _____ Province: _____ Postal Code: _____

Cell Phone: _____ Other Phone: _____

Email Address: _____

Please indicate which guardian you would like selected for each of the following in our software system

Responsible Party: _____
(This person is the one that carries the dental insurance & is responsible for payments for any balances.)

Head of Household: _____
(This person will be contacted regarding scheduling and reminders.)

Social Media/Photo Consent

Smile Buddy is pleased to participate in social media outlets where we share staff pictures, office updates, contests, fun events and special moments with our patients. With your permission we are excited to share posts welcoming new patients, congratulating patients and sharing photos of beautiful smiles.

☐ I give consent to allow Smile Buddy to post updates or photos of my child/children on social media
☐ I DO NOT give consent for photos of my child/children to be used on social media platforms

Signature: _____

We'd love to know how you were referred to Smile Buddy:

_____

Signature: _____ Date: _____

Dental Information

If a question does not apply to your child, you may leave it blank.
Let us know if you have any questions

Child's Name:_____

What has prompted your visit to our office today?

_____
_____
_____

Do you have any other dental concerns?

_____
_____

When was your child's last dental visit?

_____

Name of previous dentist:

_____

How frequently does your child normally visit the dentist?

_____

Does your child feel nervous about seeing the dentist? If so, please specify why (if you know):

_____
_____
_____

Is there anything else we should know about your child?

_____
_____
_____
_____
_____

Please check off any of the following that apply to your child's dental profile:

- ☐ Does your child frequently eat or drink foods with high sugar content? Please list:
  _____
  _____
  _____
- ☐ Does your child brush their own teeth?
- ☐ Do you floss your child's teeth?
- ☐ Does your child have head, neck, or shoulder aches?
- ☐ Does your child have clicking or popping sounds in their jaw?
- ☐ Does your child grind or clench their teeth?
- ☐ Has your child ever experienced any injuries to their face or jaw? If yes please describe:
  _____
  _____
  _____
- ☐ Does your child currently use a pacifier?
- ☐ Does your child have a habit of sucking their thumb?
- ☐ Does your child currently use a bottle or sippy cup?
- ☐ Do your child's gums bleed when brushing?
- ☐ Are your child's teeth sensitive to cold or sweetness?
- ☐ Does your child have a bad gag reflex?
- ☐ Does your child play sports that could cause injury to their teeth?
- ☐ Does your child snore?
- ☐ Has your child ever had braces? Orthodontist:
  _____

Medical Information

If a question does not apply to your child, you may leave it blank.
Let us know if you have any questions

Medical Physician: _____

Physician Phone Number: _____

Date of last visit to physician: _____

Has your child been hospitalized in the past? If yes, please describe:

_____

_____

_____

List any medications your child is currently taking:

_____

_____

_____

Has your child ever had an allergic or adverse reaction to any medication or drug including anesthetic?

- ☐ Yes
- ☐ No

Is your child allergic to any of the following?

- ☐ Latex
- ☐ Plastic bandages
- ☐ Metal
- ☐ Penicillin
- ☐ Nuts

List any other allergies:

_____

_____

_____

Does your child carry an epi pen?

- ☐ Yes
- ☐ No

Please check off any of the following that apply to your child's medical profile:

- ☐ Cardiovascular, Heart Conditions
- ☐ Bleeding disorder
- ☐ Kidney disease
- ☐ Cerebral palsy
- ☐ Epilepsy
- ☐ Febrile seizures
- ☐ Asthma: Severity? _____
- ☐ Diabetes: Type? _____
- ☐ Thyroid disorder
- ☐ Liver disorder
- ☐ Hepatitis: Type? _____
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Eating disorder
- ☐ Bone or joint problems
- ☐ Psychiatric condition
- ☐ ADHD/ADD
- ☐ Autism
- ☐ Anxiety
- ☐ Speech delay
- ☐ Premature birth
- ☐ Low birth weight
- ☐ Birth defect
- ☐ Genetic disorder
- ☐ Cancer/tumor
- ☐ Chemotherapy/radiation
- ☐ Other:

_____

_____

_____

_____

_____

_____

_____

I acknowledge I have filled out these forms to the best of my knowledge and will inform Smile Buddy of any changes

_____ _____ _____

Parent/Guardian Name | Signature | Date

Insurance Information

Let us know if you have any questions

Would you like us to direct bill to your insurance?

☐ Yes – Please Fill out Plan information and continue back side of page.

☐ No – Please Sign Below

Primary Insurance Plan:

Plan Member Name: _____Birthdate(M/D/Y): _____

Employer Name:_____

Insurance Company: _____

Group Policy Number: _____

Subscriber ID: _____

Secondary Insurance Plan:

Plan Member Name: _____Birthdate(M/D/Y): _____

Employer Name:_____

Insurance Company: _____

Group Policy Number: _____

Subscriber ID: _____

Please be aware that there will be a 25% deposit taken day of the appointment if the insurance claim does not give us a break down of coverage

_____ _____ _____

Name Signature Date

Billing Information

Let us know if you have any questions

If you request, we bill your insurance for your visits, we require to have a Credit Card on file. There is no additional charge or fee for this service. If you are unable to provide us with a valid Credit Card, you are responsible for full payment of your dental treatment at each visit. We are still able to submit claims to your insurance provider.

Important Information:

- You are required to pay any portion not covered by insurance on day of the appointment, or when response is received from your insurance provider.
- You are responsible to know the details of your dental insurance coverage, and any limitations your plan may have. Due to privacy laws we are unable to access your insurance coverage information on your behalf.
- The electronic insurance responses are an estimate provided by your insurance provider and are subject to change until the time we receive payment for your treatment.
- Please note that your insurance provider can change your coverage at any time. Therefore, you should be reviewing your policy and keeping track of any notification from your employer regarding any changes to your insurance coverage.
- If we are unable to bill your insurance for any reason, or if there is any outstanding balance on your account, you are responsible for bringing the account up-to-date immediately.
- **We will not charge your credit card without notifying you if the outstanding balance is over $500 after payment from insurance has been received. Once payment has been processed a receipt will be provided to you by email.**
- We follow the current Alberta Dental Fee Guide for Dental Specialists for any pricing on services.

Credit Card Number: _____

Expiry Date(MM/YY): _____ Name on Card: _____

Please circle: Visa / Mastercard / AMEX

List the names of any patients you give Smile Buddy permission to use this credit card for:

Name: _____

Name: _____

Name: _____

_____ _____ _____

Name Signature Date

Smile Buddy Cancellation Policy

There are many times when our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give the clinic advance notice of their need to cancel a scheduled appointment, this time can, in turn, be allocated to those patients in need of urgent treatment. In this way, the clinic can best serve the needs of ALL patients.

Bearing these special needs in mind, the **clinic requires a minimum of two business days notice if an appointment must be cancelled.** A patient research project carried out by the Canadian branch of the Academy of General Dentistry shows that most patients who cancel appointments do so in the belief that a scheduled appointment is a matter of convenience, whereas patients who keep their appointments do so because they see a scheduled appointment as a commitment to be honoured. Surveyed patients who cancel scheduled appointments were surprised to discover that a cancelled appointment on short notice (less than 24 hours) can adversely affect many other patients, specifically those who ***are suffering and in pain.***

Keeping in mind that the goal of our Clinic is to serve the needs of all patients, especially those in acute pain, our practise policy is that patients wishing to change their commitment to scheduled appointments for the sake of their convenience must give the practice a minimum of two business days notice.

If less than 2 business days notice is given to cancel an appointment, a minimum $50.00 fee will be assessed depending on the length of the appointment cancelled.

In the event that no notice is given and the patient does not show up for their scheduled appointment, a minimum $100.00 fee will be assessed depending on the length of the appointment missed.

In the event a patient does not "show up" on a second occasion, the practice policy is to ask the patient to find a different practice, at which point our administrative staff will be happy to transfer the records of that patient to a new office with a letter explaining why the transfer is being made.

Please note that insurance companies **DO NOT** cover fees for broken appointments, therefore payment is the patient's responsibility and all future scheduled, or required appointments, will no longer be held or booked respectively until the assessed fee has been paid.

***Exceptions will be made for illness or personal tragedy**

Signature:_____ **Date:**_____