Dr. Edmond Ghiabi, *Periodontist*
Dr. Negin Ghiabi, *Pediatric Dentist*

PINNACLE
DENTAL SPECIALISTS

Registration Form

Patient's Name_____ Date of Birth (D/M/Y) _____

Street Address _____ City _____

Province _____ Postal Code _____

Mailing Address (if different from above) _____

_____

Home Phone_____ Mobile Phone _____

Name of Parent/Legal Guardian _____

- Child is adopted YES NO
- Child lives in a foster home YES NO
- Child lives with a family member other than parent YES NO

Parent/Legal Guardian's Email Address: _____

Primary Insurance Coverage

Insurance Company_____ Employer_____

Policy holder Name_____ Policy holder DOB (D/M/Y) _____

Group/Plan/Policy#_____ Certificate/ID/Employee# _____

Secondary Insurance Coverage

Insurance Company _____ Employer _____

Policy holder Name _____ Policy holder DOB (D/M/Y) _____

Group/Plan/Policy# _____ Certificate/ID/Employee#_____

Health card #_____ Expiry Date (D/M/Y) _____

Parent's/Guardian's Name: _____

Patient's/Guardian's Signature: _____

Date: _____

255 Lacewood Dr., Suite 307, Halifax, NS B3M 4G2 • **Tel:** 902.407.7377 • **Fax:** 902.407.4338 • www.pdsns.ca

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Medical History

- Is your child being treated by a physician? Yes No

  If yes, for what? _____

- Has your child ever been hospitalized? Yes No

  If yes, for what reason and when? _____

- Has your child ever received general anesthesia? Yes No

  Were there any complications? _____

- Has a family member had complications during general anesthesia? Yes No

  If yes, explain_____

- Is your child allergic to any medication? Yes No

  If yes, which ones? _____

- Is your child taking any medications at this time? Yes No

  If yes, please list them? _____

- Has a physician warned you against giving your child any drug/medicine? Yes No

  If yes, what? _____

- Were there any difficulties encountered during pregnancy? Yes No

  If yes, please describe _____

- Did your child have any congenital birth defects? Yes No

  If yes, please describe _____

- Has your child ever been diagnosed with any of the following conditions:

- Anemia	- Asthma	- Bleeding disorder
- Blood transfusion	- Chickenpox	- Delay development
- Diabetes (type___)	- Frequent colds	- Hearing loss
- Heart murmur	- Hepatitis	- HIV infection
- Hyperactivity	- Impaired vision	- Jaundice
- Measles	- Mumps	- Orthopedic problems
- Rheumatic fever	- Seizure	- Sickle Cell Anemia

Child's family doctor: _____ Date of last visit: _____

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Dental History

- Who brushes your child's teeth? _____
- How often do you brush your child's teeth each day? _____
- How often do you floss your child's teeth each day? _____
- Does your child use any of the following?
  - Fluoride vitamins? Yes No
  - Fluoride rinse/gel? Yes No
  - Fluoride toothpaste? Yes No
- How many times per day does your child eat snacks? _____
- How many times per day does your child drink sugar beverages? _____
- At what age did your child completely give up bottles? _____
- At what age did your child completely give up breastfeeding? _____
- Does your child's drinking water contain fluoride? Yes No
- Has your child had orthodontic treatment? Yes No
- Is this your child's first visit to the dentist? Yes No
  - If no, were there any issues with previous visits? Yes No
- Does your child suck his/her thumb or finger? Yes No
  - If yes, briefly describe: _____
- Does your child have a dental condition that is of concern to you? Yes No
  - If yes, briefly describe: _____
- Has your child had any accidents involving his/her teeth? Yes No
  - If yes, briefly describe: _____
- Has your child had a recent injury to the head, neck or jaw? Yes No
  - If yes, briefly describe: _____

PLEASE READ THE OFFICE PRIVACY STATEMENT

By signing below, I declare that all information I have given in the above is accurate. I have read, understand and agree to the privacy statement.

Parent's/Guardian's Name: _____
Patient's/Guardian's Signature: _____
Dentist Signature: _____
Date: _____

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DENTAL PAYMENT AGREEMENT & POLICY

We would like to welcome you to our dental office and inform you of our policy regarding fees for the services provided at our office.

For patients with dental coverage:

There is no guarantee that your insurance company will fully cover the fees for the dental services provided at this office. Dental fees vary with the type of procedure and the complexity of treatment. Payment for services is due at the time of treatment.

As a convenience to you, our office will submit the charges to your insurance carrier. Since very few companies will cover the entire fee, we ask that you pay your co-payment, that is a percentage of the total fee, including any deductible, on the day the services are rendered. If the insurance company or MSI refuses payment, or does not pay in full, you will be responsible for the remaining outstanding balance.

For patients without any dental coverage:

If you do not have dental insurance, you will be expected to pay the full cost of the treatment. Payment for services is due at the time of treatment.

MSI will not cover sedation fees or occlusal x-ray fees. We will notify you of any other fees not covered by MSI before the treatment is provided.

To avoid any misunderstanding, whatever amount not covered by MSI will be your responsibility.

I understand and agree with the above payment agreement and policy.

Parent's/Guardian's Name: _____

Patient's/Guardian's Signature: _____

Date: _____

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