DR. NII A. AYI - HEALTH PLUS DENTAL CENTRE

Childs Consent for Services Authorization

First Name _____ Last Name _____ I like to be called_____

Birth date (child): _____ /_____ /_____

Address _____

_____

_____

Postal Code _____

Parent or Guardian #1) Name _____ Home#_____ Work #_____Cell#_____

Birth date:____/____/____

Insurance Co. _____ Employer _____Group # _____ Id#_____

#2) Name _____ Home# _____Work# _____Cell#_____

Birth date:____/____/_____

Insurance Co. _____ Employer _____Group # _____ Id#_____

Email address _____

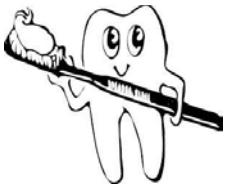
Whom may we thank for referring you? _____

Consent for Services

I understand that I am personally responsible for payment of all services rendered for my child.

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Parent/Guardian: _____ Date _____



Child's Medical History

Child's Name _____

Is the child taking any medications? Please list _____

Name of Pediatrician or Doctor: _____

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

Allergy to latex? **Y/N**

Allergy to drugs **Y/N If yes, please list:** _____

Allergy to foods **Y/N If yes please list:**_____

Asthma **Y/N If yes, please list medications taken:** _____

Behavior Problems **Y/N If Yes, please describe:** _____

Chicken Pox **Y/N If Yes, when**: _____

Hepatitis/liver disease **Y/N**

Hearing Loss **Y/N**

Kidney disease **Y/N**

Cancer **Y/N**

Cerebral Palsy **Y/N**

Diabetes **Y/N If yes, please list medications taken:** _____

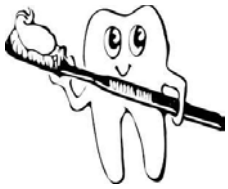
Epilepsy/Seizures **Y/N If yes, please list medications taken:** _____

Blood Disorders **Y/N If Yes, please describe:** _____

Heart Disease **Y/N If Yes, please describe:** _____

Other Medical Conditions not listed (please describe) _____

Medications taken _____



Child's Dental History

Child's Name _____

Is this the child's first visit? _____

Approximate date of last dental visit? _____

Main concerns for your child's visit today? _____

Has your child ever taken a major fall involving hitting the face or teeth? Y/N

If yes, was dental treatment required? Please describe_____

Did your child drink milk or juice continually during the infant stage? Y/N

How do you rate your child's sugar intake (This includes milk, soft drinks, juice, candy, cereals, crackers, etc) on a scale of 1- 10? _____ (1 being minimal)

Are you concerned about the development of your teeth? Y/N_____

Do you have questions about orthodontic treatment? (Braces) Y/N_____

Has your child ever had any type of orthodontic treatment Y/N _____

Does your child suck his/her thumb, fingers or use a pacifier? Y/N

Can your child breathe through his/her nose, or do you find they breathe through their mouth often? Y/N

Are you aware if your child snores or grinds their teeth? Y/N

How often does your child brush? A) Not at all
B) 1x daily
C) 2x daily
D) Couple times per week
E) Other

floss? A) Not at all
B) 1x daily
C) 2x daily
D) Couple times per week
E) Other

Does your child require help with this? Y/N

Dr. Nii Ayi Professional Corporation

Dental Office Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone number, work telephone number and email addresses (collectively referred to as "Contact Information"). Contact information is collected and used for the following purposes:

- To open and update patient files
- Invoice patients for dental services, to process credit card payments, or to collect unpaid accounts
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies
- To send reminders to patients concerning the need for further dental examination or treatment
- To send patients informational material about our office, dental materials and services
- To follow up with treatment and/or customer service

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patients' behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition and dental treatments (collectively referred to as "Medical Information"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. Patients' Medical Information is disclosed for the following purposes:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment, or the patient has asked us to submit a claim on their behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining a second opinion
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion
- To other health care professionals such as physicians if the patient, with their consent has been referred by us to other health care professionals for either a second opinion or treatment.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access, as part of the due diligence process, to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal information as set out above.

_____	_____	_____
Print Name	**Signature**	**Relationship (Parent)**