



**James Lipon Dentistry**  
**201 – 11002, 104 Avenue**  
**Grande Prairie, Alberta**  
**T8V 7W5**  
**780-539-3555**

**PATIENT CHECKLIST (PEDO – Children to be treated at QEII Hospital)**

- ☐ I agree to the administration of General Anesthetic.
- ☐ I have been informed I must not eat or drink past midnight.
- ☐ I have been informed that failure to inform the clinical staff of any food or drink consumed past midnight could result in death if GA or IV Sedation were given.

**For Children**

- ☐ Where cavities are between the teeth or where very little tooth structure remains after removing decay, the dentist treating your child reserves the treatment decision to place dental amalgam (silver fillings) or stainless steel crowns. This is what our group of dentists has determined “best practice” when treating children. Stainless Steel crowns may be used for restoration of your child’s front teeth – your child’s teeth may be silver coloured in the front. As well, teeth that have too much decay and/or infection will be removed while your child is asleep.

**For Children**

I authorize the use of silver fillings and/or stainless steel crowns when my child is receiving dental treatment.

- ☐ I have been informed of non-assignment treatment and treatment to be paid in full before we give an appointment date.
- ☐ For Social Services Clients, a \$250.00 honorarium to be paid at time of scheduling appointment. This honorarium will be returned to patient on day of treatment. Patient not adhering to instructions listed above, patient cancelling appointment with less than 48 hours notice or patient failing to come to appointment will not have honorarium refunded
- ☐ For FCH (First Canadian Health), a \$500.00 deposit to be paid at time of scheduling appointment. Any credit remaining on account after benefits received from the First Canadian Health will be returned to patient. Patient not adhering to instructions listed above, patient cancelling appointment with less than 48 hours notice or patient failing to come to appointment will not have deposit refunded.
- ☐ I have been informed that a \$500.00 fee will be imposed if appointment needs to be rescheduled because of patient not adhering to all of above, patient cancelling appointment with less than 48 hours notice or patient failing to come to appointment.
- ☐ I have been informed I/Parent or Guardian must be in contact with the OR Clerks at the QE II Hospital by 1:00 P.M. day prior to surgery. If I fail to contact QE II to go over instructions by 1:00 P.M. day prior to surgery the scheduled appointment will be cancelled and the \$500.00 deposit will be non-refundable.
- ☐ I agree that I will go back to my referring dentist once treatment is complete. Referrals will not be accepted as regular patients unless the referring doctor has advised our office in writing.



I understand that the scheduling of this treatment is dependent on the hospital wait times.  
Also, I must submit my payment as discussed above plus my completed pre-op physical form before  
I can be scheduled.

\_\_\_\_\_  
Patient Signature/Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date