New Patient Information

Please complete the following forms to allow us to get to know you and to provide the best possible care.
Please write clearly and in bold ink.
If you have any questions, or need assistance, please do not hesitate to ask.
Forms must be filled out by a parent/guardian if the patient is under 18 years of age.

Personal Information

Last Name	First Name	MI	Preferred Name
Birthdate dd/mm/yyyy	Marital Status	Email Address	
Home Ph#	Cell Ph#	Work Ph#	Work (ext.)
Address			
Apt#	City	Prov	PC

Whom may we thank for referring you to our clinic?	
Do you Prefer to receive your appointment reminders and correspondence by email?	YES NO

Emergency Contact

Name	Ph#	Relationship

Insurance Information

Name of Policy Holder		Policy Holder's Birthdate dd/mm/yyyy
Policy Holder's Employer Name	Relationship to Policy Holder: Self Spouse Child Common Law Other	
Insurance Plan Name	Group#	Cert/ID#

Do You Have a Secondary Insurance Plan? If so, please fill section below.

Name of Policy Holder		Policy Holder's Birthdate dd/mm/yyyy
Is Policy Holder a Patient?	Policy Holder's Address	
Policy Holder's Employer Name	Relationship to Policy Holder: Self Spouse Child Common Law Other	
Insurance Plan Name	Group#	Cert/ID#

Health Record

Personal Information	
Last Name	First Name
Birthdate	Age
Name of Medical Doctor	Medical Doctor Phone Number
Approximate Date of last physical and blood work?	

Medical Conditions that can affect your dental treatment:
Do you have OR have you ever had...

High Blood Pressure	Endocarditis	Seizures	Latex Allergy
Angina	Artificial Heart Valve	Diabetes	Penicillin Allergy
Heart Attack	Tuberculosis	Hypothyroidism	Mental Illness
Stroke	Hepatitis	Hyperthyroidism	Osteoporosis
Pacemaker	HIV/AIDS	Cancer	Artificial Joints
Endocarditis	Alcoholism	Bleeding Disorder	Anxiety Attack
	Illicit drug use	Eating Disorder	Smoking

Are there any other diseases/conditions that you have or have had? If so, please explain.

Please list all Medications you are currently taking or have taken within the last year:
Be sure to include supplements, vitamins and herbs.

Medication	Dose	Frequency	What do you take it for?

Please List any other allergies? Any Adverse reactions to any medications/injections?

Have you ever been Hospitalized?

Reason	Year

Are there any diseases or medical problems that run in your family? e.g. diabetes, cancer, or heart disease

Notes:

To the best of my knowledge, the above information is correct.
If there are changes in my health, I will inform the doctor at the next visit.

Patient Signature (Guardian if under 18)________________________________ Date (dd/mm/yy)_________________________

Dental Information

First Name:	Last Name:	Occupation:

Date of last visit to a dental office:	Date of last check up and cleaning:

Do you have any dental concerns at present?
Were you satisfied with your last dental office?
Is there anything we can do to make your experience as pleasant as possible?
Have you ever had a bad experience during dental treatment? Please explain

Have you ever had any of the following dental treatments? Please circle		
Teeth Cleaning	Bridges	Braces
Periodontics (gums)	Dentures	Retainers
Fillings	Dental Implants	Gum Graft
Crowns	Extractions	Root Canals

Do you suffer from any of the following? Please circle		
Swollen Gums	Food trapping between teeth	Thumb sucking
Bleeding Gums	Mouth Breathing	Shifting/moving Teeth
Receding Gums	Nail Biting	Canker sores
Sensitive Teeth	Cheek Biting	Cold sores

Home Care Routine:	
How often do you brush your teeth?	
Manual or electric toothbrush?	
How often do you floss your teeth?	
Type of Toothpaste?	
Do you use any other tools?	

Oral Appliances:	
Do you wear dentures?	
Do you snore?	
Do you have sleep disorder breathing/apnea?	
Do you play any contact sports?	
Sports Guard?	

TMJ/Bite disorders:	
Have you ever been treated for a jaw/bite problem?	
Do you wear an appliance for your bite?	
Do you think or have you ever been told you grind or clench your teeth?	
Do you have sore jaw muscles?	
Does your jaw hurt/click/pop/lock?	
Do you have an uncomfortable or unusual bite?	
Have you ever had an injury to your head, neck or jaw?	

Esthetics:	
Do you like the way your teeth look?	
Would you like to see any of your teeth straighter or reshaped?	
Have you ever whitened your teeth?	

Office Policies

Financial Policy

Financial responsibility on the part of each patient must include one of the options below. Please select an option:

☐ 1. **OPTION #1: Direct Billing to Your Insurance:**
***A credit card must be kept on file*.**
Once we have received payment from your insurance company, any balance owing will be charged to your credit card and a receipt will be mailed to you. If the outstanding amount is over $50 we will notify you by phone and automatically process the amount by 4pm the next business day.

Credit Card #: ____ VISA / MC / AMEX

Card Holder Name: ____ Expiry Date: ____ /____

Card Holder Signature: ____

☐ 2. **OPTION#2: Full Payment at Time of Service:**
Full payment is made at the time of treatment, and the insurance company reimburses you.
We will help you with any necessary forms.

Insurance Policy

- Your insurance is a contract between you, your employer and your insurance company.
- We ask that you be aware of your coverage, including maximums and limitations, and how much you have used.
- Any portion of fees not covered by your insurance plan or that exceed your insurance limit is your responsibility.
- Families that have dual insurance coverage may still have a portion of the fees not covered by either of the plans.
- 100% coverage does not always translate to 100% paid. The agreement between you and your insurance company may cover you at a reduced fee guide.
- **We are here to assist you with any questions you may have regarding your coverage. Please feel free to bring in your insurance policy booklet**.

Cancellation or Appointment Change Policy

How to Cancel an Appointment:

- If you can't make your appointment, please cancel it as soon as possible so we can help someone else.
- To cancel your appointment, call us **at least 2 business days** before your scheduled visit.

Late Appointment Changes or Cancellations:

- Not cancelling your appointment or late cancellations/changes can be costly.
- When you miss a scheduled appointment or cancel/change it within 2 business days of your appointment, we consider it as a **"no show"** that we will record in your dental record.
- We will invoice you $100 for each missed hour of time.

I agree to the Financial, Insurance and Appointment Change policies as outlined above.

Signature:__________________________ **Name:** ____________________________ **Date:** ______________________

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 described 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 numbers, work telephone numbers, and e-mail addresses. (collectively referred to as "Contact Information").

Contact Information is collected and used for the following purposes:

- To open and update patient files.
- To 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 dental practice.

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 patient's 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:

- 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 patient's behalf. To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the 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 the other health care professional 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.

____________________________	____________________________________	_________________________
PATIENT NAME	**SIGNATURE (Parent/Guardian if Under 18)**	**DATE**