Welcome! *To help us meet your dental needs kindly complete the following Confidential Patient information.*

Patient Full Name: _____ You Prefer to be called: _____

Date of Birth: D/_____ M/_____ YR/ _____ Sex: M F Age: _____

Mailing Address: _____ City: _____ Prov: ____ PC: _____

Home Phone: _____ Cellular Phone: _____ Work Phone: _____

Email address: _____

Emergency Contact Name: _____ Best Phone: _____

**Whom May we Thank for your Referral? Name _____

Radio Ad Mountainview Gazette Google Live in Area Other: _____

APPOINTMENT POLICY: Our office requests a **minimum of 48 hours** advance notice to cancel or make changes to your reserved appointment. This advance notice allows us to schedule another patient who has been waiting to see us. A fee may be applied to your account if you fail to provide notice. We thank you for your cooperation and consideration. _____ **Initial**

DENTAL INSURANCE & PAYMENT POLICY: **Kindly provide your Insurance card to our friendly administrator

Direct Billing to Insurance benefits is a courtesy we offer our patients. All patient portions are due at the time of treatment. In order to 'Direct Bill' your insurance we ask that a credit card be kept on file for any unforeseen portions not paid by your benefits. (We send claims electronically however, at times the insurance company does not confirm the exact payment for your treatment and therefore estimated portions will be collected based on basic information we have on your plan.) **We strongly advise our patients be well informed about their insurance plan as we do not have that information**. If you have financial/insurance questions about coverage, we ask that you inquite before your treatment starts. We can help you with your coverage by sending an estimate.

PORTIONS NOT PAID AT THE TIME OF VISIT ARE DUE 7 DAYS AAFTER THE FIRST STATEMENT. Portions outstanding more than 30 days where payment arrangements have not been made will have 5% interest charged monthly until the balance is paid in full. _____ Initial

I hereby agree to the Financial Policy of Didsbury Dental Centre as outlined above and authorize Didsbury Dental Centre to apply any outstanding balance on my account, not covered by my insurance provider, to the credit card listed below:

Circle Payment Option: **VISA** **Master Card** **Amex**

Card #: _____ Expiry Date: _____ CC Security Code: _____

Card Holder's Name: _____ Authorized Signature: _____

MEDICAL HEALTH HISTORY

Name of Family Physician: _____Most recent Examination: _____

Are you currently being treated for a medical condition? Yes No

If yes, please explain: _____

Women ONLY: Are you pregnant? Yes No If yes, How many weeks? _____

Do you require premedication prior to dental treatment? (ie: heart murmur, joint replacement, etc) Yes No

DO YOU HAVE OR HAVE YOU EVER HAD?

Please check yes or no:

Yes	No		Yes	No	
		Anemia			HIV/AIDS/A.R.C.
		Arthritis			Blood Pressure Problems (High or Low)
		Artificial Joints			Kidney Disease
		Asthma			Liver Disease
		Blood Disease			Anxiety
		Diabetes			Mental Illness
		Dizziness			Pace Maker
		Epilepsy			Rheumatism
		Excessive Bleeding			Sinus Problems
		Fainting			Stomach Problems
		Glaucoma			Stroke
		Head Injury			Tuberculosis
		Heart Disease			Ulcers
		Heart Murmur			Venereal Disease
		Hepatitis *(Type: _____)			Do you smoke or chew tobacco?

ARE YOU ALLERGIC OR HAVE YOU EVER HAD A REACTION TO THE FOLLOWING?

Please check yes or no:

Yes	No	
		Local Anesthetic (Freezing)
		Penicillin or other Antibiotics, please list
		Codeine, Demerol or other narcotics, please list
		Metals, please list
		Latex

Please list any current medications, vitamins or supplements or other medical conditions not listed.

_____

DENTAL HISTORY

Please check yes or no to the following questions.

Yes	No		Yes	No	
		Are you apprehensive about dental treatment?			Does the saliva in your mouth seem too little?
		Have you had problems with previous dental treatment?			Does the saliva in your mouth seem to much?
		Do you gag easily?			Have you had orthodontic (braces) treatment?
		Do you wear dentures?			Would you like to have straighter teeth?
		Does food catch between your teeth?			Have you ever noticed slow-healing sore in your mouth?
		Do you have difficulty in chewing your food?			Do you experience pain when you chew
		Do you avoid brushing any part of your mouth because of pain?			Do you have temporomandibular jaw disorder (TMD)?
		Are your teeth sensitive to cold?			Do you clench or grind your jaws frequently?
		Are your teeth sensitive to heat?			Are you satisfied with the appearance of your teeth?
		Are your teeth sensitive to sweets?			Would you like to have whiter teeth?
		Are your teeth sensitive to sours?			Do you notice an unpleasant taste or odor in your mouth?
		Do your gums bleed when you brush or floss?			Do you have sleep problems?
		Are you a habitual gum chewer?			Are you interested in discussing sedation dentistry?

How often do you brush your teeth? _____

How often do you floss? _____

Do you have an electric toothbrush or manual toothbrush? _____

Who was your Previous Dentist? _____ **Last visit?** _____

Are you interested in replacing any missing teeth? _____

Is there anything about your smile you would like to change?

_____

TREATMENT CONSENT/RELEASE AUTHORIZATION

I, the undersigned authorize Didsbury Dental Centre to perform any necessary dental services and oral surgery that I may need during my diagnosis and treatment with my informed consent. I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. I also understand that any and all dental services are my sole responsibility and that I should make myself aware of any fees associated with my dental care prior to treatment.

_____ _____ _____

Signature of Patient/Guardian Print Name Today's Date

Dental Office Personal Information Consent Form
Personal Information & Protection Act

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 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 materials
- 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 patient's behalf.

Financial information may be collect 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 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 option.
- 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 healthcare professionals, such as physicians, if the patient, with their consent, has been referred by us to the other healthcare 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.

Patient/Guardian Name Signature Date