# PATIENT INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide your dental services.

Patient Name: _____ Date of Birth: _____ Sex: ____ Age: _____
D/M/Y

Home Address: _____ City: _____ Prov: ____ PC: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

**Email:** _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Name of previous dentist: _____ Date of last visit to a dentist: _____

WHOM MAY WE THANK FOR YOUR REFERRAL: _____

## YOUR DENTAL INSURANCE INFORMATION

### PRIMARY DENTAL INSURANCE

Company Name: _____

Subscribers/Policy Holders Name: _____ DOB: _____
Day/Month/Year

Group # _____ ID or CERT # _____

Basic % of Coverage_____ Major % of Coverage _____ Maximum Per Year _____

What restrictions do you have on your dental plan? _____

(ie. How often is polishing covered? Is fluoride covered? How many units of scaling are covered?)

### SECONDARY DENTAL INSURANCE

Company Name: _____

Subscribers/Policy Holders Name: _____ DOB: _____
Day/Month/Year

Group # _____ ID or CERT # _____

Basic % of Coverage_____ Major % of Coverage _____ Maximum Per Year _____

What restrictions do you have on your dental plan? _____

(ie. How often is polishing covered? Is fluoride covered? How many units of scaling are covered?)

### INSURANCE

Direct Billing is a courtesy we offer to our patients and in order to 'Direct Bill' your insurance provider, we require a credit card on file for any outstanding amounts owing after your insurance provider has paid their portion. Outstanding accounts over 60 days will be charged 2% interest monthly. I hereby agree to the Financial Policy of Park Meadows Dental as outlined above and authorize Park Meadows Dental to apply any outstanding balance on my account, not covered by my insurance provider, to the credit card listed below:

**Payment Options are as Follows: Visa Mastercard**

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

Card Holder's Name as appears on card: _____ Authorized Signature: _____

# MEDICAL HEALTH HISTORY

Patient Name:_____

Birthdate (Month/Day/Year):_____

Emergency Contact (Name/Relationship):_____

Phone Number(s):_____

What is your estimate of your general health? (Circle one) Excellent Good Fair Poor

Do You Have or Have You Ever Had: (Check off boxes)

| | | | |
|---|---|---|---|
| Glaucoma: | | Osteoporosis/Osteopenia (i.e. Taking Bisphosphonates): | |
| Heart Problems: | | Alcohol / Drug Dependency: | |
| Heart Murmur: | | Artificial Prosthesis (i.e. Heart Valve or Joints): | |
| Rheumatic Fever: | | Tuberculosis: | |
| High Blood Pressure: | | Breathing or Sleep Problems (i.e. Snoring, Sinus): | |
| Low Blood Pressure: | | Liver Disease: | |
| HIV/AIDS: | | Arthritis: | |
| Tumor, Abnormal Growth: | | Contact Lenses: | |
| Radiation Therapy: | | Head Or Neck Injuries: | |
| Chemotherapy: | | Epilepsy, Convulsions (Seizures): | |
| Venereal Disease: | | Neurologic Problems: | |
| Are You Taking Blood Thinners: | | A Stroke: | |
| Hepatitis:(Type: ____) | | Viral Infections and Cold Sores: | |
| Anti-Depressant Medication: | | Any Lumps or Swelling in the Mouth: | |
| Anemia or Blood Disorder: | | Hives, Skin Rash, Hay Fever: | |
| Emphysema: | | Kidney Disease: | |
| Asthma: | | Thyroid or Parathyroid Disease: | |
| Hormone Deficiency | | Jaundice: | |
| Diabetes: | | Are You A Smoker Or Smoked Previously?: | |
| Digestive Disorders (i.e. Gastric Reflux): | | Are You Subject To Frequent Headaches?: | |
| High Cholesterol: | | Are You Presently Being Treated For Any Other Illness?: | |
| Stomach or Duodenal Ulcer: | | (FEMALE) Are You Taking Birth Control Pills?: | |
| | | (FEMALE) Are you Pregnant?: | |

# MEDICAL HEALTH HISTORY

Are you Allergic Or Have You Ever Had An Allergic Reaction To:

- ❑ Aspirin, Ibuprofen, Acetaminophen
- ❑ Local Anesthetic
- ❑ Fluoride
- ❑ Metals (Titanium, Amalgam, Stainless Steel)
- ❑ Latex
- ❑ Penicillin
- ❑ Erythromycin
- ❑ Tetracycline
- ❑ Codeine
- ❑ Other_____

Please List Any Medications, Vitamins, Herbal or Dietary Supplements Currently Taking AND What It Is For:

_____

_____

_____

_____

_____

_____

_____

_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE:_____ DATE: _____

# 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 too 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?_____

How often do you floss?_____

## TREATMENTCONSENT

I, the under signed, authorize Park Meadows Dental 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 Date Office Policy

Your appointment time will be reserved especially for you. If you are unable to keep your scheduled visit we require a minimum of 2 business days notification. Advance notice allows our office to see other patients who may have been waiting to see us for needed treatment. We thank you in advance for your consideration. A charge of $50.00 may apply to your account if sufficient notice is not provided.

# 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 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 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