Belle Rive Dental Clinic

First Name ____ Last Name ____ Date of Birth ____ Sex ☐ F ☐ M

Home Address ____ Apt # ____ City ____ Postal Code ____

Residential Phone Number ____ Cell Phone Number ____ E-mail Address ____

Employer / Occupation ____ Employer Phone Number ____

Emergency Contact ____ Relationship ____ Phone Number ____

Reasons for today's visit? ☐ Check-up / Cleaning ☐ Toothache ☐ Other ____

Who may we thank for referring you? ☐ Internet ☐ Outside Sign ☐ Mail/Advertisement ☐ Phone Book

☐ I live in the area ☐ Other ____ ☐ Referred by ____

MEDICAL HISTORY

Family Physician ____ Phone Number ____

1. Do you visit your family physician regularly? ☐ Yes ☐ No
2. Have you ever been hospitalized? ☐ Yes ☐ No

   If yes, why? ____
3. Please list any medications you are taking

   ____
4. Do you smoke or use tobacco? ☐ Yes ☐ No
5. Have you experienced any unusual reaction to the following? *(Check all that apply)*

   ☐ Aspirin ☐ Penicillin ☐ Valium ☐ Codeine ☐ Local Anaesthetic ☐ Latex
6. Do you have allergies of any kind? ☐ Yes ☐ No

   If yes, what? ____
7. Do you have anaemia or bleed abnormally? ☐ Yes ☐ No
8. Have you ever had any of the following diseases or conditions? *(Check all that apply)*

   ☐ Asthma ☐ Heart Problems ☐ Heart Murmur ☐ Cancer ☐ Ulcers ☐ Epilepsy ☐ Diabetes

   ☐ Kidney Disease ☐ Thyroid Disease ☐ High Blood Pressure ☐ Stroke ☐ Jaundice ☐ Hepatitis

   ☐ Mental Illness ☐ Rheumatic Fever ☐ Gastrointestinal Disease ☐ Tuberculosis ☐ A.I.D.S.
9. Are there any other medical problems we should be aware of? ☐ Yes ☐ No

   If yes, what? ____
10. Women: Are you presently pregnant? ☐ Yes ☐ No

DENTAL HISTORY

1. Who was you previous dentist? ______________________
2. Have you experienced difficulties with past dental treatment? ☐ Yes ☐ No
3. On a scale of 1-10 how do you feel about visiting the dentist? *(1 not nervous/anxious and 10 extremely nervous/anxious)*

   ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

4. When was your last dental visit? ______________
5. What was done at that time? ______________________
6. Do you have any oral habits such as clenching, grinding, thumb sucking? ☐ Yes ☐ No
7. Do you have any pain/sensitivity? ☐ Yes ☐ No Do you have jaw joint problems? ☐ Yes ☐ No
8. Do you have bleeding gums? ☐ Yes ☐ No Do you have bad breath? ☐ Yes ☐ No
9. Would you be interested in tooth bleaching/cosmetic dentistry? ☐ Yes ☐ No

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I authorize the dentist to preform procedures and consent to the treatment including the use of local anaesthetic, oral sedation. and I will assume responsibility for fees associated with those procedures. I authorize the release of my personal information regarding my diagnosis or treatment to my insurance company or any other dental profession.

______________________ ______________ ______________________

Signature ☐ Patient ☐ Parent ☐ Guardian Date Print name of parent / guardian

Belle Rive Dental Clinic Patients

As you are aware, you are fully responsible for the payment of your dental account.

When an appointment is booked, that time is reserved exclusively for you and anyone else requesting time will be denied. For this reason, a **minimum of 2 full business days notice is required to change your appointment**. Failure to provide notice will result in a minimum of a **$100 cancellation fee**.

If you do not have dental insurance, you will be required to pay your account in full after each visit. If you have a dental plan, we would be happy to direct bill your insurance company on your behalf. However, **your patient portion is due at the end of each appointment**. If there is a balance remaining after submitting to your insurance company, **this balance will be your responsibility**. All overdue accounts will be subject to interest charges.

☐ **I would like to accept your courtesy service and have you bill my insurance on my behalf. I am now aware that the dental office is not contacted by the insurance company or employer for changes in coverage or termination of coverage. Therefore, it is my responsibility to inform you.**

My Insurance Information:	Plan 1	Plan 2
Name, Relationship & DOB of Member *(i.e. self, spouse, parent)*		
Insurance Company		
Employer's Name *(that plan is through)*		
Group / Plan / Policy #		
I.D. / Certificate #		

It is your responsibility to know what benefits your insurance covers, how often services can be performed, annual maximums, and percentages.

I have read the above and agree to accept responsibility for my dental account. "My dental account" is defined as any costs incurred by any and all persons or family members receiving dental treatment and or receiving benefits on the same insurance plan at any time. Should any conditions change, I agree that it is my responsibility to notify Belle Rive Dental Clinic of these changes before any costs are incurred.

Name ______________________________ Date ______________

Signature ______________________________

APPENDIX 5

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 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, e-mail addresses, and patient photographs (collectively referred to as "Contact Information"). Contact information is collected and used for the following purposes:

- To open and update files.
- To invoice patients for dental services, to process credit card payments, or to coiled unpaid accounts.
- To process claims for payment or reimbursement from third party health benefit providers and insurance companies via electronic submission (CDA Net) or by mail.
- 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 dental treatment or has asked us to submit a claim on the patients' 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 or 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 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 of the information.

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

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

Date	Print name	Signature