

THE DATA ON THIS FORM IS CONFIDENTIAL
WE APPRECIATE YOUR COOPERATION IN FILLING IT OUT
THANK YOU VERY MUCH
(7 PAGES)

Name _____ Date of Birth (M/D/Y) ___/___/___
Address _____ Postal Code _____
Health Card # _____
Home Phone #: _____ Cell Phone # _____
Fax #: _____ E-mail Address _____
Business Phone #: _____
Business Address _____
Occupation: _____

(For Children) - Parent or Guardian Names : _____

Are you a Canadian citizen? Yes No

Name of Dental Insurance Company : _____

Policy# _____ ID# _____

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

Have you had radiation treatment in the past two years ? Yes No

Are you currently taking drugs or medication? Yes No

Please list :

Are you currently taking any over the counter medication? Yes No

Please List: _____

Are you H.I.V. positive? Yes No

Do you smoke? Yes No

How often? _____

<u>Have you ever had:</u>	Liver or Kidney Disease	Yes	No
	Diabetes	Yes	No
	Heart Trouble	Yes	No
	Healing complications	Yes	No
	Epilepsy	Yes	No
	Rheumatic Fever	Yes	No
	Ear Problems	Yes	No
	Eye Problems	Yes	No
	Hepatitis	Yes	No
	Fainting spells	Yes	No
	Jaundice	Yes	No
	Venereal Disease	Yes	No
	Respiratory Disease	Yes	No
	Anemia	Yes	No
	Asthma	Yes	No
	Prolonged Bleeding	Yes	No
	High Blood Pressure	Yes	No
	Low Blood Pressure	Yes	No

Are you allergic to any of the following:

Local anesthetic	Penicillin	Aspirin	Latex
Barbiturates	Codeine	Sulfa	

Others: _____

List any major operations that you have had:

Are you subject to cold sores ?	Yes	No
Do you regularly clean between your teeth?	Yes	No
If yes how do you do it? _____		
Have you ever been instructed in proper daily care of your mouth?	Yes	No
Are you pleased with the way your teeth look when you smile?	Yes	No
Do you experience bleeding gums?	Yes	No
Do you have an unpleasant odour or taste from your mouth?	Yes	No
Do you seem to strike some teeth before others when closing?	Yes	No
Do you get a clicking or cracking sound when you speak or chew?	Yes	No
Does food catch between your teeth?	Yes	No
Do your teeth feel loose?	Yes	No
Do you use toothpaste?	Yes	No
Do you usually have many cavities?	Yes	No
Have you lost any of your natural teeth?	Yes	No
Do you have unwanted spaces or gaps between your teeth?	Yes	No
Do you have missing teeth that you would like replaced?	Yes	No
Are you undergoing treatment at another dental office at this time?	Yes	No
Have you ever received counseling for excessive use of alcohol or drugs?	Yes	No

**OUR OFFICE DOES REQUIRE 2 (TWO) BUSINESS DAYS NOTICE TO CANCEL OR
CHANGE AN EXISTING RESERVED APPOINTMENT**

OUR OFFICE IS A SCENT FREE ZONE
YOUR CO-OPERATION IS APPRECIATED

IMPORTANT INFORMATION CONCERNING INSURANCE BENEFITS

Dental plans are changing rapidly and more reductions in benefits are occurring as companies cut their costs.

Insurance benefits are a contract between you and your insurance carrier. Ultimately you are responsible for paying the dentist for treatment and dental plans rarely pay for 100% of treatment.

Insurance companies do not inform dental offices of changes that they are making. Some companies do pay 100% but their calculations are based on an older fee guide. We use a current fee guide as a reference, but our fees are based on the skill, care, judgment and the best and most up to date materials available.

As a courtesy to you we will send pre-authorizations to your insurance company before beginning any significant work. This will enable your insurance carrier to inform you of the portion of the total cost that they will cover. Therefore you will be able to plan your finances before starting treatment.

Sometimes the insurance companies suggest an alternate treatment (cheaper). We will be glad to discuss the long-term ramifications of that type of decision with you.

The following is a list of definitions of commonly used insurance terms:

ANNUAL MAXIMUM- Most insurance companies have an annual maximum amount that they will pay out for each patient.

DEDUCTIBLE- the dollar amount that a patient pays toward treatment before their insurance coverage begins.

ELIGIBILITY- Eligibility determines who is covered under the insurance policy.

EXCLUSIONS- many dental services and treatments that are clinically necessary are not covered by dental insurance. Unfortunately in future more treatments will be excluded as insurance companies try to cut costs further.

CO-PAYMENT- Payments made by the patient to cover the portion of the bill not covered by insurance. **Co-Payments are due upon date of service.**

DUAL COVERAGE- When both spouses are covered by different insurance plans the insurance companies usually coordinate the benefits so that the patient does not receive more than 100% of the cost of the treatment.

ASSIGNMENT- Of the insurance is the situation when the patient signs a section of the insurance form which allows the dentist to receive payment directly from the insurance company.

THE DENTAL HEALTH CENTRE WELCOMES NEW PATIENTS

PAYMENT OPTIONS

To keep the cost of dentistry down and to continue to provide quality dental care to our valued dental patients, we accept payment in full upon visit.

Please check off your preferred method of payment below:

Visa # _____ Exp. _____

Master Card # _____ Exp. _____

Interact/Cash

Cheque

If you have dental insurance we will accept authorization to charge the balance of your account that is not paid by your insurance company to your credit card.

Signature _____

Date _____

I _____, hereby authorize the Dental Health Centre to process payment of the balance of charges unpaid by my insurance company.

A receipt will be mailed to you upon request.

PRIVACY STATEMENT AND CONSENT FORM

Privacy of our patients' personal information is important to us. We are committed to collecting, using and disclosing personal information responsibly.

PERSONAL INFORMATION

Personal information for our purposes is: that information necessary for the provision of professional oral health care services provided to you, and information necessary to administer this dental practice. Personal information includes all the information provided by you to us on our patient information/health history. Personal information may also include any information provided to us during the normal course of communication between patient and dental staff. We will use and disclose only information provided to us by you or another person acting on your behalf.

INFORMATION DISCLOSURE

Your personal information shall be disclosed only to those recipients who have a need to know (i.e. dental specialists, personal physicians). The information disclosed shall be restricted to only the information relevant to that recipient. You may at any time designate any restrictions as to whom we may disclose your personal information. Also you may restrict the context of a disclosure.

INFORMATION RETENTION AND DESTRUCTION

We will retain your personal information for a period necessary to continue oral health services to you, and for its related administration. We will destroy information in a secure manner when the information is no longer necessary for the provision of oral health services and is not required to be retained for compliance with federal regulations or statutes.

YOUR ACCESS TO YOUR RECORDS

We are committed to providing you with open access to your personal information held by us. You may at any time ask to see your records and request amendments to the information.

CONSENT

ACKNOWLEDGMENT

Having read and understood the **PRIVACY STATEMENT FOR PATIENT**, I consent to the collection, use and disclosure of my personal information as presented in the **STATEMENT**, subject to the restrictions identified below.

NO RESTRICTIONS _____

SIGNATURE _____

DATE: _____

RESTRICTED ACCESS:

My personal information shall not be provided to the following individuals or organizations:

RESTRICTED INFORMATION:

Personal information disclosed from the personal information collected, shall not include

SIGNATURE: _____

DATE: _____

COMPLAINT PROCESS:

Should you wish to formally complain regarding our privacy practices, please do so in writing.

CONTACT

Should you have any questions or comments, please bring them to our attention and we will be pleased to assist you.
