CANMORE downtown dental

CONTACT & INSURANCE INFORMATION *Today's Date:*________________
Full Name Mr.[ ] Mrs.[ ] Ms.[ ] Miss.[ ] ______________________________ Date Of Birth (d) __ __/(m) __ __/(y)__ __ __ __
Permanent Mailing Address:______________________________ Postal Code ________ Home # ____________
Your email address:______________________ (may we use this for appointment reminders or newsletters? Yes___, No___)
Employer: ______________________ Position Or Department: ________________ Work # ____________ Ext__________
Insurance Yes[ ] No[ ] Insurance Carrier ______________________ Policy#_______ Group#_______ ID#__________
SIN# _____________________ AHC# ________________________ Driver's License#____________________
In Case Of An Emergency Or Relocation, You May Contact: ____________________Relationship To You:________________
Emergency Contact's Mailing Address______________________________Phone Number________________________
Names Of Other Family Members Or Relatives Who Are Patients:____
Whom May We Thank For Referring You "Or" How Did You Hear About Our Office? _____________________________

DENTAL HISTORY
Previous Dentist? ____________________________ How Long Since Your Last Dental Examination? ________________
Have You Had X-rays In The Last Year? _________________________ Do You Object To Dental X-rays? Yes [ ] No [ ]
Do You Have Any Dental Problems Or Concerns Presently? ____
____
Have You Ever Had Complications From Anesthetic? Yes [ ] No [ ] Do You Bruise Easily? Yes [ ] No [ ]
Are Any Of Your Teeth Sensitive To: Cold [ ] Sweets [ ] Heat [ ] Other?____
Have You Ever Had Abnormal Bleeding Associated With Previous Extraction? Yes [ ] No [ ] ____________________
Do You Grind Or Clench Your Teeth? Yes [ ] No [ ] Does Your Jaw Crack Or Pop? Yes [ ] No [ ]
Discuss Any Past Experiences That Make You Uncomfortable Coming Into A Dental Office __________________________
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Please note any concerns, fears, or past experiences that our dental office should be aware of, so we can make your visits here comfortable:

It Is The Policy And Objective Of This Office To Emphasize Preventative Dentistry & Healthy Mouths for a Lifetime.
Do You Agree With This Approach? ___ Do You Want To Keep Your Teeth And Gums Healthy For A Lifetime? ___

MEDICAL HISTORY
Your Physician's Name: ____________________ Year Of Last Complete Exam: _______ Telephone #________________
Please note any medical concerns that our dental office should be aware of:

The Following Is Required To Thoroughly Diagnose Any Condition And Give You The Highest Possible Standard Of Care.
1. Are You Now Under The Care Of A Physician And If So, For What? ______________________________ Yes [ ] No [ ]
2. Have You Ever Had Any Serious Illness Or Operation And If So, For What? ________________________ Yes [ ] No [ ]
3. Have You Ever Been Hospitalized And If So, For What? ___________________________________ Yes [ ] No [ ]
4. Are You Presently Taking Any Drug Or Medication? Yes [ ] No [ ] Oral Contraceptives? Yes [ ] No [ ]
Specify: A) Drug ___________ Reason _____________ C) Drug ______________Reason ____________________
B) Drug____________ Reason______________ D) Drug ______________Reason ____________________
Are You Allergic Or Have You Reacted Adversely To Any Medicine? (Example: Any Antibiotics, Barbiturates, Sedatives, Analgesic/Pain Killers) Please list: ____
6. Have You Ever Had Any Of The Following Diseases Or Conditions? *Please Indicate By A Circle*

Anemia	Breathing Problems	Hearing Disorder	Rheumatic Heart	Stroke
Angina	Endocrine Problems	Heart Attack	Rheumatic Fever	Thyroid
Asthma	Congenital Heart	Fainting Spells	Heart Disease	Diabetes
Hepatitis	Gastrointestinal	Blood Disorders	Liver Disease	Epilepsy
Lesions	Blood Pressure Problems	Hormonal Disorder	Venereal Disease	Kidney
Jaundice	Pulmonary (Lungs)	Emotional Problems	Nervous Disorders	Allergies
Cancer	Head Or Face Injury	Bone Disorders	Depression	Addictions

7. Woman: Are You Or Do You Have Any Reason To Believe You Are Pregnant? Yes [ ] No [ ]
8. Do You Have Any Reason To Believe You Have Been Exposed To The Aids Virus? Yes [ ] No [ ]
9. Do You Require Any Premedication Prior To Your Dental Visits? Yes[ ] No [ ]
10. Please Discuss Any Other Medical Conditions Not Listed Above That You Feel We Should Know About?

Please fill out the next page…

PATIENT CONSENT AND CERTIFICATION FORM **Date:_______________ Patient's Name:__________________________**

Personal Information Protection and Electronic Documents Act (PIPEDA under Federal Legislation)

Privacy of your personal information is an essential part of our office providing you with quality, professional care. We understand the importance of protecting your personal information. We are committed to collecting, using, disclosing your personal information responsibly. If you have any questions/concerns or need to obtain information, please contact our onsite Privacy Information Officer (PIO). If you need to transfer your records to another office, the PIO will need you to 1st sign a release. Storage, retention, destruction of your personal information complies with existing legislation. *I know that your office has a Privacy Code, and give permission to this office to collect, use, disclose my personal information accordingly. My information may be accessed by the regulatory authorities under the terms of the RHPA for defense on a legal issue. *Your Signature:*_________________

Consent to Treatment

I authorize The Dentist, or whomever he designates, to perform advisable treatment & radiographs as agreed upon throughout the course of treatment. If procedures change from what was originally contemplated, I will be provided with additional explanations of procedures & expenses. I acknowledge that no guarantee/assurance has been made to me as to the results that may be obtained. I understand that the laws of the Province of Alberta will govern this Consent to Treatment, I consent to the courts of Alberta having exclusive jurisdiction to entertain any action, suit, or proceeding. *Your Signature:*_________________

Consent to Anesthetic (when needed)

I consent to the administration of local anesthetic as indicated or required, and understand that in extremely rare circumstances paraesthesia (numbness) may result from the administration of local anesthetic. *Your Signature:*_________________

Certification and Release of Medical History

I certify that I have provided an accurate & complete medical history and have not knowingly omitted any information. I have had the opportunity to ask questions & receive answers to any questions about my medical history. I give this office permission to obtain & release any personal medical information to & from my other health-care providers. I understand it is my responsibility at each visit to inform this office of any changes to my medical status. *Your Signature:*_________________

Appointments

There are times our patients need emergency treatment & require an appointment ASAP! Please be courteous & call us promptly (with 2-3 business day's notice) if you are unable to attend an appointment, so we may call another patient requiring an urgent visit. We pre-appoint all appointments for recommended treatment to prevent patients from dealing with the consequences of incomplete treatment, requiring unscheduled emergency care. I agree with this procedure. *Your Signature:*_________________

Emergency Care Only-Consent

I understand Emergency Treatment is for my immediate/specific problem & should not be regarded as a Complete (through) Examination of my mouth & dental needs. Only the one immediate issue is addressed. *Your Signature:*_________________

Electronic Claims Submission Release

I authorize release, to my insurance company, information contained in claims submitted electronically. *Your Signature:*_________

Responsibility of Fees for Services Rendered & Dental Insurance

I assume full responsibility for fees associated with services. I understand that Insurance Benefits are **not** the responsibility or controlled by the dental team, I must consult my work administrator or insurance carrier for information. Under the Privacy Act, insurance carriers are only to release information to the subscriber, making it difficult for the dental teams to estimate "costs on services after insurance coverage". The only way you can obtain an "exact" breakdown of benefits is to have us file a pre-authorization of Treatment, this can take some time to obtain breakdowns. Our staff is happy to assist you with claim submissions when you have provided us with all your accurate and current insurance, employer, financial & mailing information, but we are not liable for amounts paid by your insurance carrier. Insurance Companies have their own Fee Schedules in place, they usually don't release this information to subscribers or dental providers, so it is difficult to determine exactly how much they will reimburse for treatment, which leaves us "estimating" how much may or may not be covered by insurance at the end of each appointment.
*I agree to take full responsibility of my insurance & billings at each appointment. *Your Signature:*________________

We offer patients flexibility & accuracy in Payment with the following 2 options. Which option BEST works for you?

Option #1: OFF Assignment

This is the most popular & easiest option! You are in control of your insurance benefits, by paying us in full for treatment at each appointment & being reimbursed directly by your insurance company. You are able to keep a personal record of all dental transactions, insurance reimbursements & to track how close you are to using your yearly maximum of benefits. You will never have an outstanding account balances with us & you do not need to leave a current credit card on file with us. Often, patients pay with credit cards, earn air miles/points & receive the insurance payment before they have to pay the balance on their credit card.
I, _______________________(print name), prefer OFF assignment. Signature:____________________ Date:_____________

Option #1: ON Assignment, Credit Card Express Check-out Program

You authorize the Dental Office to submit your claim & Accept Assignment (Payment) of Benefits from your Insurance Carrier. We will collect the "estimated" portion/difference at the end of each visit. You authorize us to keep a current credit card on file to process payments or refunds on the day we receive the insurance payment. If your insurance company has not paid us within 60 days after Treatment, you authorize us to use the credit care pay down you dental account, and you will be responsible for contacting the insurance company to be reimbursed from them. We extend the courtesy of waiting up to 60days to be paid from insurance companies, but no longer. I, _______________________(print name), prefer ON assignment.
I, _________________________(print name), authorize Canmore Downtown Dental to keep my signature & current credit card on file to issue any payments or refunds at time of treatment, as well as clear outstanding accounts after 60 days from my Treatment.
Today's Date:_______________Cardholder Name:________________________Cardholder Signature:____________________
Circle Card Choice: Visa or MasterCard C/C Number:______________________Expire Date:_________Security #__________