HIGH RIVER DENTAL CENTRE
HRDC

Patient Registration

All information is confidential

PATIENT: _____

First Name Last Name Preferred Name

Date of Birth (D/M/Y): _____ Age: _____ Sex: _____ Marital Status: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell phone number for text message confirmations: _____

E-mail address for confirmations: _____

If under 18 years of age, Parent or Guardian name: _____

First Name Last Name Date of Birth (D/M/Y) Phone Number

Person to call in case of emergency: _____ Cell #: _____

First Name Last Name

Whom may we thank for referring you? _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important inter relationship with the dentistry that you will be receiving. Thank you for answering the following questions. **All information is confidential**.

1. When was your last medical exam? _____ Physician's Name _____

Are you presently under the care of a physician or have you been during the last 5 years? ☐ Yes ☐ No

If Yes, explain: _____

2. Have you ever had a serious illness, accident requiring hospitalization or extensive medical care? ☐ Yes ☐ No

Specify: _____

3. Do you use any prescription or non-prescription medicine (including birth control)? If so please list:

Drug _____ Reason _____

Drug _____ Reason _____

Drug _____ Reason _____

4. Have you ever experienced any unusual reaction to any of the following? (please check)

☐ local anaesthesia ☐ sulfa drugs ☐ latex/rubber ☐ aspirin (ASA) ☐ erythromycin
☐ barbiturates ☐ penicillin ☐ metal (nickel) ☐ codeine ☐ other _____

Have you ever been warned against taking any drug or medication? ☐ Yes ☐ No If Yes, please specify _____

5. Do you have or have you ever had any of the following (Please check and or circle)

☐ arthritis or rheumatism ☐ epilepsy or seizures ☐ hyper or hypo glycemia ☐ stomach/intestinal problems
☐ asthma ☐ fainting or dizziness ☐ jaundice ☐ stroke
☐ back problems ☐ heart attack ☐ kidney/liver disease ☐ thyroid disease
☐ cancer/radiation/chemo ☐ heart murmur/mitral valve prolapse ☐ malignant hyperthermia ☐ tumors
☐ convulsions ☐ herpes ☐ mental or nervous disorder ☐ other _____
☐ cortisone/steroid therapy ☐ hepatitis A B or C ☐ organ/medical implants
☐ diabetes ☐ HIV positive ☐ scarlet or reheumatic fever
☐ drug/alcohol addiction ☐ high low blood pressure ☐ sinus trouble

6. Do you have any blood disorders such as anemia? ☐ Yes ☐ No

7. Have you ever had any injury, surgery or radiation therapy to your face or jaws? ☐ Yes ☐ No

If Yes, explain: _____

8. Do you have frequent severe headaches? ☐ Yes ☐ No

9. Do you have any disease, condition or problem that you think the doctor should know about? ☐ Yes ☐ No

10. Height _____ Weight _____

WOMEN ONLY Are you pregnant? ☐ Yes ☐ No If Yes, what month are you in? _____

****Please Note: cancellations or re-scheduling of appointments made less than 24 hours prior to your scheduled appointment may be subject to a $50.00 cancellation charge****

PATIENT CONSENT AND APPROVAL

I have had the opportunity to ask and to receive answers or explanations regarding my medical/dental history. I, the undersigned, certify that all of the medical and dental information is true to my knowledge and I have not omitted any pertinent information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary and consent to my physician being contacted if necessary.

Signature: _____ Date: _____

day/month/year

High River Dental Centre
Account and Payment Policy

Cancellation Policy

24 hours notice is required for cancellation of all appointments except under special circumstances. A $50.00 cancellation fee may be charged if special circumstances do not apply.

Payment

Payment is due on the date of service: we accept Visa, MasterCard, American express, Debit and Cash.
Any payment plans must be discussed with the administrator prior to treatment and a valid credit card must be left on file.

Personal Insurance Coverage

Your personal insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services such as direct billing and providing a pre-treatment estimate at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits you are entitled with your plan. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Non-residents, patients with out-of-province insurance, or any others listed above must provide full payment for each appointment on the date of the appointment. A claim will be processed for those individuals so that they may receive reimbursement from their insurance carrier.

Most insurance claims are now sent electronically, not requiring a patient's signature. For those claims that cannot be sent electronically, it is the patient's responsibility to ensure all paperwork is completed and signed.

The patient portion owing on the claim must be paid on the date of the appointment when the insurance carrier provides that information on an electronic claim response.

When an electronic claim does not provide the patient portion owing on the claim or, if a claim cannot be sent electronically, the following will apply:

1. The patient portion owing will be estimated at 20% of all claims generally considered "basic" and is payable on the date of the appointment.

2. The patient portion owing will be estimated at 50% of all claims generally considered "major" and is payable on the date of the appointment.

Special Circumstances

Our foremost concern is the dental health of all of our patients. Special financial arrangements can be made with our Business Administrator. If a payment plan is required all arrangements must be made prior to the commencement of your treatment.

All insurance payments must be provided within 45 days. If the insurance carrier does not provide payment within 45 days, the patient is responsible for the payment and must seek reimbursement from their insurance carrier.

Patients who do not have insurance coverage or who have insurance carriers who do not honor assignment, must provide full payment on the date of the appointment.

I have read and understand all of the above terms and conditions.

Date: _____ _____
(Patient/Parent or Guardian signature)

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 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 the 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 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 opinion.
- 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 health care professionals such as physicians if the patient, with their consent, has been referred by us to the 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 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.

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

I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically.

This authorization shall continue in effect until the undersigned revokes the same.

_____	_____	_____
Date	Print Name (patient, parent or guardian)	Signature (patient, parent or guardian)