

WELCOME TO CHINOOK SMILES

Patient Name	Parent/Guardian
Address	Date of Birth <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Prefer not to say
City	Email
Postal Code	Emergency Contact
Home Phone	Family Physician
Cell Phone	How Did You Hear About Us?
Work Phone	

MEDICAL HISTORY (please check all that apply):

<input type="checkbox"/> Anaemia	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Angina	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fainting	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Asthma/Hay Fever	<input type="checkbox"/> Head/Neck Radiotherapy	<input type="checkbox"/> Rheumatic/Scarlet Fever
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Heart Attack/Stroke	<input type="checkbox"/> Rheumatoid Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Defect/Valve	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Cortisone/Steroid Treatment	<input type="checkbox"/> Hepatitis (A, B, C)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> HIV/Immuno-compromised	<input type="checkbox"/> Ulcers/Colitis
<input type="checkbox"/> Diabetes (Types I/II)	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Venereal Disease

Please list and describe any other medical conditions:

ALLERGIES AND MEDICATIONS

Are you allergic or sensitive to any of the following? (please check all that apply)

Medication	Details/Date	Medication	Details/Date
<input type="checkbox"/> Antibiotics		<input type="checkbox"/> Sulfa Drugs	
<input type="checkbox"/> Latex		<input type="checkbox"/> Local Anesthetics	
<input type="checkbox"/> Codeine		<input type="checkbox"/> Other	
<input type="checkbox"/> NSAIDS (ASA or Ibuprofen)		<input type="checkbox"/> Other	

Please list any medications you take and provide the name of your pharmacy:

PHARMACY NAME: _____ PHONE #: _____

Medication	Condition Treated	Medication	Condition Treated

Do you smoke? Yes No If so, how much?

FOR WOMEN ONLY Are you pregnant? Yes No Due Date _____

Are you nursing? Yes No Until? (estimate) _____

SIGNATURE

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held to the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental procedures with my informed consent that I may need during diagnosis and treatment.

Signature _____

Date _____

PERSONAL INFORMATION CONSENT

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 the 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/find 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 patient concerning the need for further dental examination or treatment.
- To send patients informational material about our dental practice.

Contact information disclosed to third party health benefits 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.

Personal information from our patients about their health history, 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 treatments.

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 their 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 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 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.

Date

Print Name

Signature

FINANCIAL CONSENT

Thank you for selecting us as your personal dental team. We are very proud of our knowledgeable, well-trained, and caring dental team. You will find us dedicated to helping you maintain your optimum oral health.

Please take time to familiarize yourself with our office procedures and policies.

- No charge will be made for rescheduling an appointment, provided 48 business hours notice is given, otherwise a charge may be incurred. Once an appointment has been made, please remember this time has been reserved specifically for you.
- Your dental insurance is a contract between you and your insurance company. We cannot guarantee payment or coverage of your claim. Our fees are based on the 2018 Alberta Dental Fee Guide. Insurance policies vary greatly. Therefore, owing to the complexity of Insurance contracts, you are fully responsible for knowing your own insurance plan. Treatment is recommended based on what you need, NOT on what you are covered for. As a courtesy, we will prepare and submit claims on your behalf. Full payment will be required if your insurance does not allow direct billing. We are happy to work with you to help you understand your dental benefits. We encourage you to bring in your insurance booklet so that we can review it with you.
- Balances are to be paid in full at each appointment, unless written financial arrangements are made in advance of your treatment. Please discuss payment options and fees with our staff, and they would be pleased to work with you to make the required arrangements.
- For your convenience, we accept the following forms of payment: cash, Visa, MasterCard, direct payment (Interac), or MasterCard.

YOUR FINANCIAL CONSENT

The patient/guardian agrees that he/she is fully responsible for payment of procedures performed in this office, including any treatment not a covered benefit of any dental insurance the patient may have.

I certify I have read and understand the above.

PATIENT/GUARDIAN SIGNATURE

DATE

PAYMENT POLICY

As a courtesy, we will direct bill to your insurance. Please note that payment is expected at each appointment as determined by your insurance plan or lack thereof. A credit card number will be kept on file for any balances not covered by your plan. Should you choose to decline to provide us with the information, we will assume non-assignment for your dental plan. For your convenience, we offer the following methods of payment. Please check your preferred payment option.

- Visa
- MasterCard
- American Express

Card # _____

Expiry: month ____ year _____

Signature _____