WELCOME TO CHINOOK SMILES

Patient Name	Parent/Guardian
Address	Date of Birth ☐ M ☐ F ☐ 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):

☐ Anaemia	☐ Drug/Alcohol Abuse	☐ Kidney Disease
☐ Angina	☐ Emphysema	☐ Leukemia
☐ Anorexia/Bulimia	☐ Epilepsy/Seizures	☐ Liver Disease
☐ Arthritis	☐ Fainting	☐ Osteoporosis
☐ Artificial Joints	☐ Glaucoma	☐ Pacemaker
☐ Asthma/Hay Fever	☐ Head/Neck Radiotherapy	☐ Rheumatic/Scarlet Fever
☐ Bleeding Disorder	☐ Heart Attack/Stroke	☐ Rheumatoid Disease
☐ Cancer	☐ Heart Defect/Valve	☐ Sinus Problems
☐ Chronic Pain	☐ Heart Murmur	☐ Thyroid Disease
☐ Cortisone/Steroid Treatment	☐ Hepatitis (A, B, C)	☐ Tuberculosis
☐ Depression/Anxiety	☐ HIV/Immuno-compromised	☐ Ulcers/Colitis
☐ Diabetes (Types I/II)	☐ High Blood Pressure	☐ 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
☐ Antibiotics		☐ Sulfa Drugs	
☐ Latex		☐ Local Anesthetics	
☐ Codeine		☐ Other	
☐ NSAIDS (ASA or Ibuprofen)		☐ 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 _____

DENTAL HISTORY

What are your treatment goals for your teeth? Short term: _____
Long term: _____

Are you having any pain or discomfort at this time? Y N
Have you ever had a complication with past dental work? Y N

On a scale of 1 – 10 (1 being not nervous at all, 10 being extremely nervous to just sit in the chair), please rate your comfort with dental appointments _____

What can we do to make your visit more comfortable? _____
Approximate date of last appointment _____

Please check if any of the following apply to you:

- o Teeth sensitive to heat or cold
- o Teeth sensitive to sweets
- o Teeth sensitive to biting pressure
- o Broken fillings or rough edges
- o Food gets stuck between your teeth
- o Gums bleed or feel tender when you brush/floss
- o Frequent cold sores, canker sores, or any other mouth sores
- o Have you ever experienced a skin reaction to jewellery or watches?

Are you aware of grinding or clenching your teeth?	Y	N
Are you aware of sleep apnea or snoring?	Y	N
Does chewing gum bother your jaw?	Y	N
Are you aware of any popping, clicking or grinding noises when you move your jaw?	Y	N
Do you suffer from chronic headaches or chronic pain in the neck or back?	Y	N

Do you think your teeth are worth keeping for a lifetime?	Y	N
If you could safely whiten your teeth, would you be interested?	Y	N
Is there anything you would like to change about your smile?		

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_____ _____
Signature of Patient Date

I verbally reviewed the medical and dental information above with the patient herein. _____

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 2019 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, or direct payment (Interac).

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 _____