SOUTH
FAMILY DENTAL
General Dentistry

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## PATIENT INFORMATION

☐ Mr ☐ Mrs. ☐ Miss ☐ Ms. ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Name _____
Last First Middle

Address: _____
City Province Postal Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: (circle) Female Male
dd mm yy

Employer: _____ Occupation: _____

Email:_____ Spouse's Name_____

Are other family members patients at our office: (circle) Yes No

Would you like appointment confirmations via text messaging or email? (circle) Email Text Message

Who can we thank for your referral to our office? (please circle) _____

Family Friend Brochure Newsletter Live Close By Internet Website Signage Other

## INSURANCE INFORMATION

| **Name of Primary Policy Holder** | **Date of Birth** dd/mm/yy | **Primary Insurance Company** | **Group Policy Number** | **ID or Certificate Number** |
|---|---|---|---|---|
| | | | | |
| Patient's relationship to policy holder: | Self ☐ | Spouse ☐ Child ☐ | Other ☐ | |

| **Name of Secondary Policy Holder** | **Date of Birth** dd/mm/yy | **Secondary Insurance Company** | **Group Policy Number** | **ID or Certificate Number** |
|---|---|---|---|---|
| | | | | |
| Patient's relationship to policy holder: | Self ☐ | Spouse ☐ Child ☐ | Other ☐ | |

****PLEASE NOTE: EVERY INSURANCE POLICY IS DIFFERENT AND INSURANCE BENEFIT BOOKLETS ARE GUIDELINES ONLY. IT IS THE RESPONSIBILITY OF THE POLICY HOLDER AND PATIENT TO KNOW YOUR POLICY COVERAGE, NOT THE RESPONSIBILITY OF THE DENTAL OFFICE.**

## IMPORTANT CONTACTS

| In case of emergency, notify: | Relationship | Phone Number |
|---|---|---|
| | | |

| Family Physician | Clinic Name and/or Address | Phone Number |
|---|---|---|
| | | |

# SOUTH FAMILY DENTAL

## Personal Information Privacy Act

We are committed to protecting the privacy of our patients' personal information and to use all personal information in a responsible and professional manner and disclose personal information only when permitted or required by law.

**Personal Information Procedures**
We receive contact, medical and financial information about our patients such as names, home/work addresses, home/work phone numbers, e-mail addresses, date of birth, insurance plan details, health/dental histories, emergency contact information.

**Contact information** is disclosed to third party health benefit providers and insurance companies, with the CONSENT OF THE PATIENT for purposes of submission of claims, reimbursement or payment of dental care, predetermination of dental treatment, open and update patient files, invoice patients for dental services, process dental claims, and to send reminders to patients concerning the need for further dental treatment.

**Medical information** is disclosed, with consent of the patient, to other dentists, dental specialists, or health care professionals such as physicians. It is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

**Financial information** is collected for payment processing purposes. It is not shared with third parties unless permitted by law for outstanding bill collection purposes.

## Insurance Policy Matters

**I am aware that South Family Dental direct bills to my insurance company as a courtesy to me** and the dental office accepts **no responsibility** for any uncovered amounts, amounts over allowed benefit maximums, plan limitations or restrictions, etc. South Family Dental has advised me that I make myself aware of my dental plan and know my coverage. My dental insurance policy is an agreement between me and my insurance company. The insurance company does not permit releasing any information to the clinic due to the Health Privacy Act. We want to make you aware of this fact. Dental providers usually receive payments four weeks after treatment and sometimes longer if you have more than one insurance plan. **Please note that every insurance policy is different. It is the responsibility of the policy holder and the patient to know your policy coverage. It is NOT the responsibility of the dental office.**

**Please remember that under no circumstance is it customary for an insurance company to cover a dentist's fee in full.** Our fees are reasonable and competitive according to Alberta Dentists Association Standards. **You are responsible for payment regardless of your insurance company's determination of the amount.**

**Please keep track of you yearly maximums, limitations, appointment dates and accumulated amounts used on your dental plan.** South Family Dental has advised me to contact my plan provider should I have any questions.

**All accounts must balance zero within 30 days after insurance claim is paid to our office. Therefore we require a credit card to be put on file in order to set your account balance to zero.** A 2% monthly interest charge will be applied to unpaid balances over 30 days.

Thank you for understanding our Policy and cooperation. Please let us know if you have any questions.

I consent to the collection, use and disclosure of my personal information as set out above and that of my dependents. **I authorize South Family Dental to keep my signature on file to charge any credit/debit memos, as well as outstanding payments in the event of short-notice cancellation/missed appointment and remaining balances after my insurance claims have been paid, to my credit card. I agree to keep South Family Dental updated with a current credit card and inform of any changes in my insurance following treatment. This credit card information will be kept on a separate confidential file that is secure. A receipt will be emailed to you if provided.**

**Signature of Patient:** _____ **Date:** _____

# SOUTH FAMILY DENTAL CLINIC POLICIES

## Perio Laser

South Family Dental utilizes the laser gum treatment which reduces bacteria, prevents cross contamination (infected pockets in one area of your mouth can spread to other areas) and kills bad bacteria the may cause periodontal disease. Results may vary. We recommend laser gum treatment at each cleaning.

## Cancellation Policy

Due to a high demand in prime appointment times, we require **48 hours** advanced notice should you need to reschedule your appointment. If you cancel or no show, we lose two patients: you and the person who would have been treated in that time slot. I acknowledge that without proper notice, I will be charged **a $100 fee** that is uncollectable by a third party and is my personal responsibility to pay.

X _____
Initials

## Direct Billing

Due to the Canadian Personal Privacy Act, we are unable to access any sufficient information from your insurance company regarding your dental plan. It is **your responsibility to know the details involved in your plan**, such as annual maximums, frequencies, and any other limitations. We extend the **courtesy to bill your insurance** directly, however to avoid any patient portion discrepancies, please be fully aware of the particulars of your plan so you can utilize your benefits to their maximum. South Family Dental can only provide estimates when requested so you may budget your finances accordingly. South Family Dental is pleased to offer you the following payment options. Please check which option you would like to participate in.

☐ **Option A** Payment is due in full the day treatment is rendered. We accept Cash, Visa, Debit, and MasterCard. South Family Dental will process your payment on the date treatment is given. Our treatment coordinator will help you in submitting the necessary documents to your insurance carrier and the insurance cheque will be sent directly to you, the patient.

☐ **Option B** You will be required to leave your credit card number on file and we will direct bill your insurance company. Any outstanding amounts will be applied to your credit card on file once your insurance company has paid us their portion.

If we receive an explanation of covered costs from your insurance company at the time of your visit, you will be required to pay the outstanding balance before you leave.

Please sign below acknowledging that you have read and that you understand the office policies at South Family Dental.

**Date:** _____ **Signature:** _____

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## For Option B only:

I, _____, have chosen **Option B**, and hereby authorize any balances outstanding which is not covered by my dental insurance to be **automatically** applied to:

Name (*as it appears on card*): _____

Card Number: _____- _____- _____- _____ Expiry Date: _____

Credit Card **(circle one)** : Visa MasterCard CVV (3 digits on back of card): _____

Signature of Cardholder: _____

Patients this card applies to: _____

**Receipts will be emailed to the following address upon request:** _____

# MEDICAL HISTORY

**The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.**

NAME:_____ DATE:_____

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

   ❒ YES ❒ NO _____

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? If yes, please explain.

   ❒ YES ❒ NO _____

4. Are you taking any medications, non-prescription *drugs* or herbal supplements of any kind? If yes, please list.

   ❒ YES ❒ NO _____
   _____

5. Do you have any allergies? If you answered yes, please list using the categories below:

   ❒ YES ❒ NO

   a) medications _____
   b) latex/rubber products _____
   c) other, e.g hay fever, foods _____

6. Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain.

   ❒ YES ❒ NO

7. Do you have or have you ever had any heart or blood pressure problems?

   ❒ YES ❒ NO _____

8. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?

   ❒ YES ❒ NO _____

9. Do you have a prosthetic or artificial joint?

   ❒ YES ❒ NO

10. Have you ever been advised by your doctor to take premedication (antibiotics) before dental treatment?

    ❒ YES ❒ NO

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy).

    ❒ YES ❒ NO _____

12. Have you ever had hepatitis, jaundice or liver disease?

    ❒ YES ❒ NO

13. Do you have a bleeding problem or bleeding disorder?

    ❒ YES ❒ NO _____

14. Have you ever been hospitalized for any illness or operations? If yes, please explain.

    ❒ YES ❒ NO _____

15. Do you have or have you ever had any of the following? Please check.

| | |
|---|---|
| ❒ arthritis | ❒ pacemaker |
| ❒ asthma | ❒ prosthetic heart valve |
| ❒ cancer | ❒ seizures (epilepsy) |
| ❒ chest pain, angina | ❒ shortness of breath |
| ❒ diabetes | ❒ steroid therapy |
| ❒ diet pill therapy | ❒ stomach ulcers |
| ❒ heart attack | ❒ stroke |
| ❒ kidney disease | ❒ thyroid disease |
| ❒ lung disease | ❒ tuberculosis |

16. Are there any conditions or disease not listed above that you have or have had? If so, what?

    ❒ YES ❒ NO _____
    _____

17. Do you smoke?

    ❒ YES ❒ NO

18. Does your jaw crack or pop when opened wide?

    ❒ YES ❒ NO

19. **For women only:** Are you pregnant or breast -feeding? If pregnant, what is the expected delivery date?

    ❒ YES ❒ NO _____

**In order to avoid complications as a result of a change in your medical condition, it is important you notify this office of any changes**