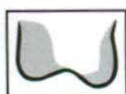


est Calgary Dental Group

Registration

Date: ________________ day/mo/yr

Patient Name: ________________________________

Seen as a / an
- ❒ Adult
- ❒ Child Parent's name: ________________
- ❒ Under guardianship by: ________________

Birthdate: ________________ day/mo/yr

AB Health Care #: ________________

Email: ________________ Occupation: ________________

Family information already on file?	Yes / No

Best Telephone Number ________________ ❒ Cell ❒ Work ❒ Home
Alternate ________________ ❒ Cell ❒ Work ❒ Home

Address: ________________________________
Street / #

____
City / Town Postal Code

Other family members attending our office?	Yes / No

____

Did you hear about us from:
- ❒ A personal referral:
  - Whom may we thank? ________________
  - Relationship ________________
- ❒ Website
- ❒ Signage
- ❒ Advertisement
- ❒ Other: ________________

Dental Insurance
- ❒ I will present benefit card(s)
- ❒ I am interested in 3rd party financing

Dental Q & A

Last visit to the dentist? ❐ < 1 year ❐ 1-5 years ❐ > 5 years

Name of Past Dental Office (if necessary) ____________________

Most Recent Treatment
- ❐ Cleaning
- ❐ Fillings
- ❐ Other

Rate your past experiences
❐ good ❐ fair ❐ poor

Past Treatments

- ❐ Gum surgery / Periodontics
- ❐ Tooth Removal
- ❐ Braces / Orthodontics
- ❐ Appliances (grinding guards / plates)
- ❐ Implants
- ❐ TMJ Studies
- ❐ Dentures
- ❐ Cosmetic Fillings / Veneers
- ❐ Crowns / Bridges
- ❐ Sleep Apnea

Other:

Present Situation

- ❐ Gum problem
- ❐ Pain / Something broken
- ❐ Loose teeth / Missing teeth
- ❐ Bite problem
- ❐ Jaw Joint Issue / TMJ
- ❐ Wisdom Teeth Concern
- ❐ Grinding / Clenching
- ❐ Poor looking teeth / Broken
- ❐ Food-catch
- ❐ Sleep Apnea

Other:

Are you interested in

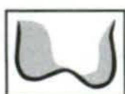
- ❐ Whiter straighter teeth
- ❐ Sedation
- ❐ Better bite
- ❐ Pre-Retirement Dental Plan
- ❐ Cavity Free Kids for Life
- ❐ Sports Guard
- ❐ Amalgam removal
- ❐ Replacement teeth / Implants
- ❐ Cosmetic Rejuvenation
- ❐ House Call

Other points to note

❐ anxiety concerns 1-------------------10 (most)

❐ I need ____________________

STAFF INITIAL ____________________ PATIENT INITIAL ____________________



West Calgary Dental Group

Medical Q & A

Medical Doctor's Name: ☐ current ☐ not current

List known allergies or adverse drug reactions:

List current medical condition(s) or on-going tests:

List other current medications and/or supplements:

Or ☐ see attached

Do you have a history of:

- ☐ cardiovascular problems (heart disease, stroke, pacemakers, previous surgery) or blood pressure concerns?
- ☐ asthma or a breathing problem like shortness of breath?
- ☐ antibiotics required before treatment?
- ☐ bleeding disorders or blood thinners in use?
- ☐ heart murmurs, a history of rheumatic fever?
- ☐ back or spine concerns?
- ☐ joint replacements?
- ☐ liver problems or infectious diseases?
- ☐ rash, bowel problems or a chronic cough?
- ☐ seizures
- ☐ diabetes
- ☐ stomach ulcers
- ☐ memory problems
- ☐ sleep apnea
- ☐ something else ____________

STAFF INITIAL ____________ PATIENT INITIAL ____________

Payment of Fees:

We are pleased to offer you a variety of payment options. Please check which you would like to participate in:

☐ Payment is due in full on day of treatment. If you have dental insurance our administration staff will assist you with submission and the cheque will be sent to the plan subscriber. We accept Visa, MasterCard, Debit and cash. Payment plans can be arranged in advance of the start of treatment.

☐ West Calgary Dental Group will direct bill your insurance. You will be required to leave a valid credit card or a cash deposit on your account with us to cover any outstanding amounts. If we receive and explanation of benefits from your insurance the outstanding balance will be collected on the day of the appointment.

Credit Card ☐ VISA ☐ MC

Card # ________ - ________ - ________ - ________

Exp. Date _____ /_____

Signature ______________________

Estimates of treatment will be provided upon request and pre-authorizations sent to your insurance company for approval. Services and fees may vary during treatment due to unforeseen factors. Every effort will be made to update the patient but a new written estimate may not be provided. The account holder is ultimately responsible for full payment and accuracy of insurance information.

West Calgary Dental adheres to legislation in the Alberta Health Information Act to keep your personal information private, including credit card authorization.

Please sign below to acknowledge that you have read and understand:

Date: ________________ Signature: ______________________

Email: ______________________________

Privacy Statement

We protect the privacy of our patient's personal information and utilize 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 and work telephone numbers (collectively referred to a "Contact Information"). Contact information is collected and used for the following purposes:

i) to open and update patient files
ii) to invoice patients for dental services, to process credit card payments, or to collect unpaid accounts
iii) to process claims for payment from third-party health benefit providers and insurance companies on the patients behalf

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has asked the office to submit a claim on their behalf.

Financial information may also 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 past medical and dental treatments (collectively referred to as "Medical Information"). Patients' medical information is collected and used for the purpose of diagnosing dental conditions and to provide treatments.

Patients' medical information is disclosed:

i) to third party health benefits providers and insurance companies where the patient has requested the office submit a claim for reimbursement of all or part of the cost of dental treatment of their behalf
ii) to other dentists and dental specialists, where we are seeking a second opinion
iii) 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
iv) to other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion
v) to other health care professionals such as physicians if the patient, with their consent, has been referred by us to other health care professionals for either a opinion or treatment

As a member-office of the Alberta Dental Association and College, and affiliated with the Alberta Health Services, our records may be inspected and our staff interviewed as part of their regulatory activities and in the public interest.

____________________________   ____________________________

signature   date