

Periodontal New Patient Intake Form



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Name: _____ Date of Birth: _____ **A.H.C. #:** _____
Home Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____ **Email:** _____
Emergency Contact Name: _____ **Cell Phone:** _____
If Patient is a minor, name of Parent / Guardian: _____ Phone (if different from above): _____
Current Dentist: _____ How long have you been a patient of your current dentist? _____

If you were not referred to us by your current dentist, how did you hear about us: Word of mouth Lifepath The Anchor
 Facebook Internet search / Website Family / Friend Other _____

Health History

Periodontal disease may be caused by a combination of several factors and the following questions are designed to help us identify them. The success of therapy is dependent upon this. Therefore, although some of the following questions may seem unrelated to your periodontal condition, they are all associated with proper management of your oral health and your information is kept confidential.

Medical Physician: _____ Date of last physical exam: _____

Are you presently being treated by a physician for a certain condition or concern? Y / N If yes, what for? _____

Are you taking any medications now? Y / N If yes, please list: _____

Do you have or suspect that you may have Acquired Immune Deficiency Syndrome? Y / N

Do you have any in-dwelling medical devices (hip or knee replacement, heart valve or pacemaker)? Y / N If yes, what device and when was it implanted? _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

- | | | |
|-----------------------------------------------|-----------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Asthma / Hay Fever | <input type="checkbox"/> Abnormal Blood Count | <input type="checkbox"/> Seizures or Convulsions |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hives or Skin Rash | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Thyroid or Parathyroid Disorder |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Tumor or Growth | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer - Type: _____ | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Arthritis or Rheumatism |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Lupus | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tendency to Faint | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prostate Disorders |

Has your general health changed in the past year? Y / N If yes, in what way? _____

Has your weight changed in the past year? Y / N Please explain: _____

Have you ever had any serious illness or major surgery? Y / N If yes, please explain. _____

Have you had abnormal bleeding associated with a previous tooth extraction, trauma or surgery? Y / N

Do you heal slowly? Y / N

Have you ever had any allergies (food, dust, drugs, fur, latex, etc)? Y / N _____

Are you allergic to or have you had an adverse reaction to any of the following:

- | | | |
|---------------------------------------------------------------|----------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Dental anaesthetics (novocaine, etc) | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Barbiturates (sleeping pills) |
| <input type="checkbox"/> Penicillin or other antibiotics | <input type="checkbox"/> Codeine | <input type="checkbox"/> Peanut allergy |
| <input type="checkbox"/> Other drugs: _____ | | |

Have you ever been warned against taking any drug or medicine? Y / N If yes, please explain: _____

Have you ever had an asthmatic attack? Y / N

Are you ever short of breath or have chest pains after mild exertion? Y / N

Do your ankles swell? Y / N

Are you thirsty much of the time? Y / N

Has anyone in your family ever had diabetes? Y / N Who? _____

Do you have a persistent cough or do you cough up blood? Y / N

Do you consider yourself a nervous person? Y / N

Have you ever received psychiatric care? Psychotherapy? Y / N

Have you ever had surgery or treatment for a tumor or growth of your head, mouth or lips? Y / N

Do you smoke or have you ever smoked or used other tobacco products? Y / N

If yes, how long? _____ Date quit? _____ Product used: _____

Do you often consume more than 2 alcoholic beverages per day? Y / N

Women: Are you pregnant? Y / N **Please inform our office if you become pregnant prior to or during the course of treatment.**

Do you know that certain medications (eg: antibiotics) may inhibit the effectiveness of contraceptives? Y / N

- **To the best of my knowledge all of the preceding answers and information provided are true, complete and accurate.**
- **I grant permission to you and your assignees to telephone me to discuss matters related to this form.**
- **I understand that this information is held in the strictest confidence and it is my responsibility to inform the office of any changes to my medical or dental history.**
- **I hereby give consent to have a periodontal (dental) examination and/or relief of pain treatment. This treatment may include use of various medication such as: local anesthetic (freezing), antibiotics, analgesics (pain killers) and others as required.**

Signature

Date

Printed Name

OUR APPOINTMENT POLICY

Thank you for allowing us the privilege of being your Dental Health provider. Our practice is dedicated to quality care and is pleased to reserve time exclusively for each patient.

We respect our patients' time and make every effort to remain on schedule. Despite careful scheduling, dental emergencies can cause delays. If your appointment time is affected due to an unforeseen emergency, we will try our best to notify you in advance. We know that your time, like our Doctor's, is valuable and we will make every effort to see you on time and will ensure you are given the same time and attention for your dental health.

Because we reserve time exclusively for you, we ask that you make every effort to keep your reserved appointment time. If you find that you cannot keep your scheduled visit, **we require a minimum of 2 business day's notification**. Advance notice allows our office to see other patients who may have been waiting to see us for needed treatment. We thank you in advance for your consideration. A charge of \$75.00 may apply to your account if sufficient notice is not provided; this charge is at the discretion of your Doctor.

_____ *initial*

FINANCIAL POLICIES FOR PATIENTS WITH DENTAL INSURANCE

(IMPORTANT: Please read and initial if you request direct billing to your Insurance,

if you wish to pay in full for your dental treatment and be reimbursed by your dental plan, please disregard this section.)

Many of our patients have dental insurance. While your dental insurance policy is an agreement between you and your insurance company, we will be happy to assist you in preparing and sending in the necessary forms. Please remember that no insurance company attempts to cover all dental costs. We cannot render dental treatment on the assumption that our charges will be paid in full by an Insurance Company. Full payment to our office remains your responsibility, regardless of how much your insurance does or does not pay. (Please see the attached information on dental insurance for more information.)

I am aware that Chestermere Station Dentistry direct bills my Insurance Company as a courtesy to me and that in doing so, the dental office accepts no responsibility for any uncovered amounts, amounts over benefit maximums, limitations or plan restrictions, etc. I understand that the dental office collects my dental coverage information as a guideline ONLY to assist me in maximizing my benefits this does not hold them responsible for my dental account. Chestermere Station advises that I make myself very aware of my dental plan, knowing my coverage and that I ask my dental team about any and all procedures I am authorizing.

_____ *initial*

Chestermere Station Dentistry advises me to contact my plan administrator or Insurance Company for questions regarding eligible procedures and authorization of treatment. And to make myself aware of all costs involved with my dental care. Chestermere Station advises me to keep track of my yearly maximums, limitations, appointment dates, and accumulated amounts used on my dental benefit plan.

_____ *initial*

Payment is due at the time of service. I am aware that if the dental office does not receive confirmation from my Insurance for their exact payment— Chestermere Station will estimate my portion only at the time of visit. Any unforeseen balances will then be informed to me by statement. I agree to pay all of these uncovered portions within **10 days** from the date of statement or interest charges of 5% per month may be applied to my account. I agree to pay these interest charges if applied to my overdue account.

_____ *initial*

I also understand that any uncovered procedures that may have been done at another Dental office are my responsibility.

IMPORTANT: Please be advised that complete oral examinations (new patient exams) & x-rays will be denied by your insurance if you have had this procedure at another dental office within the time limitations on your specific plan. You are responsible for this procedure in our office should this not be an eligible benefit with your coverage.

_____ *initial*

I am aware that NSF fees (returned cheques) are \$50 for every returned personal cheque.

_____ *initial*

ACCOUNTABILITY CONFIRMATION

I, the undersigned, clearly understand all policies of Chestermere Station Dentistry. I understand and agree to pay all fees associated with my dental treatment. With or without dental coverage, I agree it is my responsibility to make myself aware of those fees prior to any dental treatment.

Signature

Date

Printed Name

DENTAL OFFICE PERSONAL INFORMATION CONSENT

Privacy Act Information

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 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 further dental examination or treatment
- To send patients informational material about our dental materials
- To follow up with treatment and/or customer services

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 for the following purposes:

- 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.

Signature

Date

INSURANCE INFORMATION

Insurance Information (or you may provide your insurance card for us to copy and keep on file)

If your plan does not allow to pay the Dentist directly, you are responsible to pay in full for your treatment on the date of service.

Primary Plan - For children, the parent whose birth month comes first in the year is Primary plan

Insurance Company: _____ Group #: _____

ID or Certificate #: _____ Employer/Company Name: _____

Subscriber/Policy Holder's name: _____ Subscriber Date of Birth: _____

Secondary Plan

Insurance Company: _____ Group #: _____

ID or Certificate #: _____ Employer/Company Name: _____

Subscriber/Policy Holder's name: _____ Subscriber Date of Birth: _____

YOUR DENTAL INSURANCE



Canadian
Dental
Association
L'Association
dentaire
canadienne

Many patients possess employer-sponsored dental prepayment plans, often referred to as “dental insurance.” These plans are not considered insurance in the traditional sense. Instead, these plans cover a portion of the fees for dental services utilizing prepaid benefits, which are traditionally part of your compensation plan. We are not privy to the specifics of each of these plans, and not all dental plans are the same.

Alberta dentists set their own fees for services. The Alberta Dental Association and College has also provided practice management information and courses to dentists, to help them in determining costs and how to set fees. The fees set by dentists are based on a number of factors, including the time and complexity of the services provided, provincial requirements for maintenance and sterilization, the value of that service to the patient, and overhead costs of staff, materials, rent, loans, bank financing, insurance, continuing education, and utilities among others. Fees are not based upon availability of a dental plan, insurance or what coverage is available for specific services.

Your health and well-being is our concern. Our providers make treatment recommendations based upon your individual needs and health requirements. We do not base our treatment plans or recommendations upon the level of insurance available to you. However, it is your responsibility to know what coverage is available to you. You can obtain coverage information directly from your company or organization's plan administrator or insurance carrier before visiting the dentist. If you have concerns regarding your dental plan or insurance coverage, contact your employer's human resources department, union leader or employer for details. It is unlikely that any dental plan would cover every service that you may need.