DENTAL CLINIC PATIENT INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name: ____________________________________ Date of Birth: ___________________ Sex: ___ Age: _____

Home Address: ____City: __________________________

Province: ____________ Postal Code: ________________

Home Phone: ______________________ Mobile Phone: ____________________ Email: _________________________

Emergency Contact Name: _______________________ Relationship: _______________ Phone: ___________________

Medical Doctor: ________________________________ Date of last visit to Medical Doctor: ______________________

Name of Previous Dentist: ________________________ Date of last visit to Dentist: _____________________________

FINANCIAL POLICY

Payment Options are as follows: Cash & Interac (Debit), Visa, Master Card, and American Express

Please choose Option 1 or Option 2:

- **OPTION 1 – Non-Assignment:**
  All accounts are paid by you, at the time of service, and the Insurance Claim (if any) is sent electronically by our office at the time of your appointment. The Insurance payment is mailed directly to you and may be received in as little as three days.
  I, the undersigned, hereby agree to the Financial Policy of Dental Centre as outlined above.

  ____ ________________________________
  Signature **Date**

- **OPTION 2 – Assignment:**
  In order to "Direct Bill" your Insurance provider, we require a credit card on file for any outstanding amounts owing after your Insurance provider has paid their portion. Each Insurance provider has their own fee guide that they use to calculate your coverage. Insurance providers pay a percentage of their fee guide, not a percentage of our office fee guide. Because of this, it is impossible to estimate exactly how much your Insurance provider will reimburse you. We strive to calculate the most accurate estimate for reimbursement; however, there may be a balance owing. We cannot send out statements for all these balances and this is when we will charge the balance owing to your credit card on file. We will make every attempt to contact you to advise you of any balances over $100.00. We will then mail you a receipt, along with a copy of the Explanation of Benefits from your Insurance provider for your records.
  I hereby agree to the Financial Policy of Dental Centre as outlined above and authorize Dental Centre to apply any outstanding balance on my account, not covered by my Insurance provider, to the credit card listed below:

Visa ☐ **Master Card** ☐ **American Express** ☐

Card #: ___________________________ Expiry Date: _______/_______ CC Security Code: _______________________

____ ____

Card Holders Name as it appears on card **Authorized Signature**

DENTAL CLINIC

DENTAL OFFICE PERSONAL INFORMATION CONSENT FORM/PERSONAL INFORMATION AND PROTECTION ACT

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 patients' 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 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 patients' 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 healthcare 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.

____________________	____________________	____________
Patient/Guardian Name	**Signature**	**Date**