SUBMIT

RESET

SAVE

NORTH POINTE
FAMILY DENTISTRY

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you may be asked additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:_____ Date of Birth:_____ ❑ Male ❑ Female

Address:_____City:_____ Prov:____
Postal Code:_____I prefer to be called (If different from legal name)_____

Preferred method of contact:

❑ Home Phone:_____ ❑ Cell Phone:_____
❑ Work Phone:_____ ❑ Email:_____

Occupation:_____
How did you hear about our practice?:_____

Emergency Contact:_____Relationship:_____Phone:_____

Insurance information:

Primary Coverage

Insurance Company:_____ Group #:_____ID #:_____

Policy Holder Name: _____Date of Birth (mm/dd/yy):_____

I hereby assign my benefits payable from my claims and those of my dependants to North Pointe Family Dentistry and authorize payment to North Pointe Family Dentistry.

*Policyholder's Signature:*_____

Secondary Coverage

Insurance company:_____ Group #:_____ ID #:_____

Policy Holder name:_____Date of Birth:(mm/dd/yy)_____

I hereby assign my benefits payable from my claims and those of my dependants to North Pointe Family Dentistry and authorize payment to North Pointe Family Dentistry.

Policy Holder's signature: _____

Medical History:

Please mark (X) your response to the following questions. ***Mark "DK" if you don't know the answer.***

Physician Name:_____Phone:_____
Date of last physical exam:_____

Yes No DK

1) Are you in good physical health?_____.
2) Has there been any change in your general health within the past year?_____
*If yes, what condition is being treated?*_____
3) Are you taking, or have you ever taken, an antiresorptive agent (eg. Actonel, Fosamax) for osteoporosis or Paget's disease?_____
4) Do you smoke or use tobacco in any form?_____.

Do you have or have you ever had: Yes No DK 5) Orthopedic total joint (ie. hip, knee, elbow) replacement?
6) Artificial (prosthetic) heart valve?_____7) Previous infective endocarditis?_____
8) Damaged valves in transplanted heart?_____9) Congenital heart disease?_____

10) Please list any prescription and over-the-counter medications you are taking including vitamins, herbal preparations or dietary supplements: _____

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ High blood pressure medicine
- ❑ Nitroglycerin
- ❑ Osteoporosis (bone density medicine)
- ❑ Thyroid medicine

Women only: Yes No DK 11) Are you pregnant?_____
12) Are you nursing?_____

13) Are you allergic to any of the following? ❑ I have no allergies.

❑ Aspirin ❑ Dental Anaesthetics ❑ Latex ❑Sulfa Drugs ❑Other (please list): ❑ Clindamycin ❑ Erythromycin ❑ Nitrous Oxide ❑Tetracycline ❑ Codeine ❑ Jewellery/Metals ❑ Penicillin ❑Valium

14) Do you have or have you ever had any of the following conditions? ❑ I have no medical conditions.

HEART

❑ Angina ❑ Arteriosclerosis ❑ Cardiovascular disease ❑ Congestive heart failure ❑ Damaged heart valves ❑ Heart attack ❑ Heart murmur ❑ High blood pressure ❑ Low blood pressure ❑ Mitral valve prolapse ❑ Pacemaker ❑ Rheumatic heart disease

LUNGS

❑ Drug / Alcohol dependence ❑ Asthma ❑ Glaucoma ❑ Bronchitis ❑ Hemophilia ❑ Emphysema ❑ Kidney disease ❑ Tuberculosis ❑ Liver disease

STOMACH

❑ Lupus ❑ Eating disorder ❑ Gastrointestinal disease ❑ Ulcers

ENDOCRINE

❑ Diabetes - Type I or II ❑ Glandular disorders ❑ Thyroid disease
❑ Mental / Nervous disorder (specify:_____) ❑ Organ transplant / Implant
❑ Osteoporosis ❑Sexually transmitted infection ❑ Sinus trouble ❑ Other (please list):_____

NEUROLOGICAL

❑ Chronic pain ❑ Epilepsy ❑ Fainting spells ❑ Severe headache / migraines ❑ Stroke

MISC.

❑ AIDS or HIV infection ❑ Anemia ❑ Arthritis ❑ Blood transfusion ❑ Cancer / Chemotherapy Radiation treatment

NORTHPOINTE
FAMILY DENTISTRY

Dental History:

Please mark (X) your response to the following questions. ***Mark "DK" if you don't know the answer.***

Why have you come in to the dentist today?_____

Date of last dental exam / dental x-rays: _____

Yes No DK

1) Do you require antibiotics before dental treatment?_____

2) Have you ever had any complications with local anaesthetic ("freezing")?_____

If yes, please explain: _____

3) Have you ever had any abnormal bleeding associated with previous tooth extractions?_____

4) Have you ever had a serious injury to your head, mouth or neck?_____

5) Do you have tension headaches or sore teeth?_____

6) Do you grind or clench your teeth?_____

7) Do you have any jaw clicking, popping or discomfort?_____

8) Do you have any TMJ pain?_____

9) Do your gums feel swollen or tender?_____

Yes No DK

10) How often do you brush?_____.

11) How often do you floss your teeth?_____.

12) Are your teeth sensitive to hot, cold, sweets or pressure?_____

13) Do your gums bleed when you brush or floss?_____

14) Is your mouth dry?_____

15) Do you snore?_____

16) Have you noticed an unpleasant taste or odour in your mouth?_____

17) Do you have sores or ulcers in your mouth?_____

18) Have you ever had orthodontic (braces) treatments?_____

19) Have you had any periodontal (gum) treatments?_____

20) Do you wear dentures or partials?_____

21) Have you experienced problems with any previous dental work?_____ _____

If yes, please specify: _____

NORTHPOINTE
FAMILY DENTISTRY

Name:_____

• As a courtesy to you, our office will bill your insurance company directly ("assignment of benefits") as long as we have a **valid** credit card on file.

• **If your insurance informs us of the difference on the day of treatment,** you have the option to pay the difference by Visa, MasterCard, debit or cash while in our office.

• **If your insurance does not inform us of the difference, we will use the credit card on file to collect the balance owing once we receive the insurance payment.** You will be notified in advance of any charge in excess of $200.00.

• We ask that you be aware of your coverage, including maximums and limitations, and how much you have used. We do not have access to this information.

• Families that have dual insurance coverage may still have a portion of the fees not covered by either of the plans.

• 100% coverage does not always translate to 100% paid. The agreement between you and your insurance company may cover you at a reduced fee guide. We are here to assist you with any questions you may have regarding your coverage. Please feel free to bring in your insurance policy booklet.

A valid credit card must be kept on file in order for us to accept assignment of benefits from your insurance company.

Credit card number:_____ ❑ VISA ❑ MASTERCARD Expiry:___/___ CVS Code:_____
Print name as it appears on card:_____Cardholder signature:_____

Financial responsibility on the part of each patient must include one of the options below. Please select an option:

❑ **OPTION #1 - Direct Billing to Your Insurance:**
A credit card must be kept on file. Please fill out the ***Insurance Information Form***.

❑ **OPTION #2 - Full Payment at Time of Service:**
Full payment is due at time of treatment and your insurance company reimburses you (if applicable). We accept cash, debit, MasterCard and Visa.

How to Cancel an Appointment:
• If you can't make your appointment, please cancel it as soon as possible so we can help someone else.
• To cancel your appointment, call us **at least 2 business days** before your scheduled visit.

Late Appointment Changes or Cancellations:
• When you miss a scheduled appointment or cancel/change it within 2 business days of your appointment, we consider it a "**no show**" that we will record in your record and you will be charged a "missed appointment fee" of $60.00. We offer a **courtesy** reminder call or email, but it is up to you, the patient to record your appointment day and time in a calendar. **Not receiving a reminder call is not an excuse for missed appointments.**

I confirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
I authorize the dental staff to perform the necessary dental services I may need.
I agree to the Payment Policy and Appointment Policy as outlined above.

I am the ❑ patient ❑ parent / legal guardian. *For parent / legal guardian please indicate your date of birth:* _____
Signature

NORTHPOINTE
FAMILY DENTISTRY

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 law.

We collect contact information from our patients (names, addresses, phone numbers, Email address, employer's names and work phone numbers) for the following purposes:

- To open & update patient files.
- To process credit card payments and 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 office.

Contact information is disclosed to third party health benefit providers and insurance companies when the patient has submitted a claim for reimbursement, or payment (of all or part of) the cost of dental treatment, or the patient has asked us to submit a claim on their behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect medical information from our patients about their health history, their family health history, physical condition, and dental treatments. Patients' medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' medical information is sometimes disclosed to the following:

1. • Third party health benefit providers and insurance companies when 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.
2. • Other dentists and dental specialists when we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
3. • Other dentists and specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
4. • Other dentists and dental specialists when those dentists have asked us, with the consent of the patient, to provide a second opinion.
5. • 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 were to sell 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 & College, who 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.

Printed Name:_____ Signature:_____ Date:_____