NEW PATIENT FORM

We are committed to providing you the most comprehensive care and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better care we can give you. If you have any questions or need assistance, please ask us – we will be happy to help!

ABOUT YOU

Name: LAST NAME FIRST NAME Preferred name: _____ Birthday: DD / MM / YYYY

Age: _____ Marital Status: _____ Address: _____ Postal Code: _____

Home phone: _____ Work: _____ Ext.: _____ Cell: _____

Email Address: _____

Preferred method of contact: ☐ Text ☐ Call ☐ Email

Do you consent to receive occasional information and promotions? ☐ Yes ☐ No

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as above

Name: LAST NAME FIRST NAME Birthday: DD / MM / YYYY Relation: _____

Billing Address: _____ Postal Code: _____

Home phone: _____ Work: _____ Ext.: _____ Cell: _____

EMERGENCY CONTACT

Name: LAST NAME FIRST NAME Relation: _____

Home phone: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____ Phone: _____ Policy #: _____ID #: _____

Insured's Name: LAST NAME FIRST NAME Insured's Birthday: DD / MM / YYYY Relation: _____

Employee # (if applicable): _____ Insured Employer: _____

Secondary Insurance

Insurance Company: _____ Phone: _____ Policy #: _____ ID #: _____

Insured's Name: LAST NAME FIRST NAME Insured's Birthday: DD / MM / YYYY Relation: _____

Employee # (if applicable) _____ Insured Employer: _____

Reason for today's visit? ☐ Check-up ☐ Cleaning ☐ Toothache ☐ Other: _____

Who may we thank for referring you? ☐ Internet ☐ Outside Sign ☐ Mail/Advertisement ☐ I live in the area

Other_____ Referred by: _____

MEDICAL HISTORY

Family Physician _____ Phone Number _____

Preferred Pharmacy _____ Phone Number _____

1. Do you visit your family physician regularly? ..... Yes ☐ No ☐

2. Have you ever been hospitalized? ..... Yes ☐ No ☐

If yes, why? _____ What year? _____

3. Please list any medications/drugs you are taking _____

_____

4. Do you use the following? (If yes, please check box)

☐ tobacco ☐ vaping ☐ cannabis

5. Have you experienced any unusual reaction to the following? (If yes, please check the box)

☐ aspirin ☐ penicillin ☐ valium ☐ codeine ☐ local anaesthetic ☐ latex

6. Do you have allergies of any kind? .....Yes ☐ No ☐

If yes, what? _____

7. Do you have anemia or bleed abnormally? ..... Yes ☐ No ☐

8. Have you ever had any of the following diseases or conditions? (If yes, please check the box)

☐ **A.I.D.S**	☐ **Heart murmur**	☐ **Mental illness**
☐ **Asthma**	☐ **Heart problems**	☐ **Rheumatic fever**
☐ **Cancer**	☐ **Hepatitis A, B or C**	☐ **Stroke**
☐ **Diabetes**	☐ **High blood pressure**	☐ **Tuberculosis**

☐ **Epilepsy** ☐ **Jaundice** ☐ **Thyroid disease**

☐ **Gastrointestinal Disease** ☐ **Kidney disease** ☐ **Ulcers**

Notes:

_____

_____

_____

9. Are there any other medical problems we should be aware of? ..... Yes ☐ No ☐

If yes, what? _____

10. Women: Are you presently pregnant? ..... Yes ☐ No ☐

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I authorize the dentist to preform procedures and consent to the treatment including the use of local anaesthetic, oral sedation, and I will assume responsibility for fees associated with those procedures. I authorize the release of my personal information regarding my diagnosis or treatment to my insurance company or any other dental profession.

_____ DD / MM / YYYY _____

Signature: ☐ **Patient** ☐ **Parent** ☐ **Guardian** **Date** **Print name of parent / guardian**

DENTAL HISTORY

1. Who was your previous dentist? _____

2. Have you experienced difficulties with past dental treatment? ..... Yes ☐ No ☐

3. On a scale of 1-10 (1 not nervous/anxious and 10 extremely nervous or anxious) how do you feel about visiting the dentist? _____

4. When was your last dental visit? _____

5. What was done at that time? _____

6. Do you have any pain/sensitivity? Yes ☐ No ☐ Do you have jaw joint problems? ..... Yes ☐ No ☐

7. Do you have bleeding gums? Yes ☐ No ☐ Do you have bad breath? ..... Yes ☐ No ☐

8. Would you be interested in tooth bleaching? ..... Yes ☐ No ☐

9. Do you suffer from HEADACHES? Do you grind your teeth? Did you ever consider **BOTOX** treatment? ..... Yes ☐ No ☐

10. Are you happy with your smile? Yes ☐ No ☐ Please rate your smile: Lowest **1 2 3 4 5 6 7 8 9 10** Highest

11. Have you heard of **INVISALIGN**? ..... Yes ☐ No ☐

Need more information? Ask us now. Were happy to help.

APPOINTMENT POLICY

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. Our office policy states that patients must give us 1 business day (24 hours) notice if they cannot keep an appointment. Appointment changes with less than 24 hours notice are subject to a $75.00 service fee. It is my responsibility to confirm appointments and I understand that if I do not confirm my appointment, there is a risk of the appointment being rescheduled. Patients that do not show up for their appointments may not be booked again.
INITIALS _____

FINANCIAL POLICY

For your convenience, our office will directly bill your insurance company, the estimated patient portion will be the balance due at the end of treatment. We do accept Cash, Debit, Visa, MasterCard and AMMEX. Dental Insurance plans often pay less than the actual fee for service. Therefore, you are responsible for all costs that the dental insurance plan does not cover. If you would like to know what your insurance plan(s) will cover, please ask us and we can ask your insurance company. We encourage patients to have pre-authorizations for all major work (Crowns, bridges, Veneers) to have a better idea of what your insurance plan will cover.
INITIALS _____

AUTHORIZATION AND CONSENT

General consent to Treatment

I agree and consent to a dental examination by the Dentists of Acacia Dental Centre. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Acacia Dental Centre to release any information regarding my dental/medical history, diagnosis, or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Acacia Dental Centre.
I understand and will comply with Appointment Policy.
I understand and will comply with the office Financial Policy.
I understand and agree to the General Consent to Treatment.
I authorize the Release of Information.
I authorize the Assignment of Insurance Benefits.

Signature: _____ **Date:** DD / MM / YYYY

APPENDIX
Dental Office Personal Information Consent Form

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 information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses and patient photographs (collectively referred to as "Contact Information"). Contact information is collected and used for the following purposes:

- To open and update 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 practice.

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:

- 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 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 or 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 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 of the information.

Dentists are regulated by the Alberta Dental Association and College whom may inspect our records and interview our staff as part of the regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal information as set out above.

DD / MM / YYYY	LAST NAME FIRST NAME	_____
Date	**Print name**	**Signature**