NORTHWEST DENTAL

3604 52 Ave NW, #206
Calgary, AB, T2L 1V9

Phone (403) 282-7933
Fax (403) 284-9675

NEW PATIENT INFORMATION

First Name:_____Last Name_____Date of Birth_____Gender_____

Address:_____City:_____Province_____Postal Code_____

Mobile Phone:_____Home Phone:_____Email_____

Parent/Guardian if under 18_____

Preferred method of contact? ❑ phone ❑ sms ❑ email

How did you hear about us? ❑ google search ❑ social media ❑ referral ❑ other

Who may we thank for referring you?_____If other please explain_____

In case of emergency, we should notify:

Name_____Relationship_____Phone_____

Dental Benefits

Do you have insurance? ❑ Yes ❑ No

Policy holder's name _____

Policy holder's DOB_____

Name of Ins. Co._____

Group/Policy #_____

Member ID_____

Employer_____

Do you have secondary insurance? ❑ Yes ❑ No

Policy holder's name _____

Policy holder's DOB_____

Name of Ins. Co._____

Group/Policy #_____

Member ID_____

Employer_____

Please read carefully and choose One option

❑ **Option 1** - This requires you to PAY IN FULL the day of treatment and we can assist you with submitting claims to your insurance if necessary.

❑ **Option 2** - Direct Billing to your insurance by us, and AMOUNTS NOT COVERED by your insurance will be your responsibility to pay on THE DAY OF SERVICE. If we are unable to find out your coverage information, 30% will be taken, and any over-payment will be refunded to you, after insurance payment has been received.

Credit Card Information (if you want us to handle balance for you).

First Name_____Last Name_____

Card Type ❑ Visa ❑ Amex ❑ Mastercard

Credit Card Number_____Security Code (CVV)_____

Expiration Date (mm/yyyy)_____

_____, I consent to the financial responsibility for any amounts not covered by my dental insurance for the dental treatments provided, and consent us to charge your credit card on file.

Signature_____Date_____

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Adult Patient ❑ Yes ❑ No

Occupation_____

Employer_____

Child Patient ❑ Yes ❑ No

Mother's Name_____

Mother's Phone_____

Father's Name_____

Father's Phone_____

Person responsible for account_____

MEDICAL HISTORY

Name of family doctor_____ Doctor's Phone_____

1. Are you being treated for any medical condition at the present or have you been treated within the past year?
   ❑ Yes ❑ No If yes please explain_____
2. When was your last medical checkup?_____
3. Has there been any change in your general health in the past year? ❑ Yes ❑ No
   If yes please explain_____
4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ❑ Yes ❑ No
   If yes please list medications_____
5. Do you have any allergies? ❑ Yes ❑ No
   If yes please explain_____
6. Is there anything we should know that may trigger anxiety? ❑ Yes ❑ No
   If yes please explain_____
7. Have you ever had a peculiar or adverse reaction to any medicines or injections? ❑ Yes ❑ No
   If yes please explain_____
8. Do you have or have you ever had asthma? ❑ Yes ❑ No
9. Do you have or have you ever had any heart or blood pressure problems? ❑ Yes ❑ No
10. Do you have or have you ever had an artificial valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congential heart disease) or heart transplant? ❑ Yes ❑ No
    If yes please explain_____
11. Do you have a prosthetic or artificial joint? ❑ Yes ❑ No
12. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ❑ Yes ❑ No
13. Have you ever had hepatitis, jaundice, or liver disease? ❑ Yes ❑ No
14. Do you have a bleeding problem or bleeding disorder? ❑ Yes ❑ No
15. Have you ever been hospitalized for any illness or operations? ❑ Yes ❑ No
    If yes please explain_____

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16. Do you have or have you ever had any of the following?

- ❑ chest pain, angina
- ❑ rheumatic fever
- ❑ pacemaker
- ❑ stroke
- ❑ stomach ulcers
- ❑ kidney disease
- ❑ osteoporosis medications
- ❑ shortness of breath
- ❑ mitral valve prolapse
- ❑ lung disease
- ❑ steroid therapy
- ❑ arthritis
- ❑ thyroid disease
- ❑ drug/alcohol dependency
- ❑ heart attack
- ❑ heart murmur
- ❑ tuberculosis
- ❑ diabetes
- ❑ seizures (epilepsy)
- ❑ cancer

17. Are there any conditions or diseases not listed above that you have or have had? ❑ Yes ❑ No

18. Are there any disease or medical problems that run in your family (e.g. diabetes, cancer, heart disease)? ❑ Yes ❑ No

19. Do you smoke or chew tobacco products? ❑ Yes ❑ No

20. Are you nervous during dental treatment? ❑ Yes ❑ No

21. **WOMEN ONLY** - Are you:

Pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pills? ❑ Yes ❑ No

DENTAL HISTORY

1. When was your last dental visit?_____Reason?_____

2. How often do you visit the dentist?_____

3. How often do you brush your teeth?_____

4. How often do you floss your teeth?_____

5. Do any of the following cause tooth discomfort? ❑ Cold ❑ Hot ❑ Sweets ❑ Chewing

6. Are you having any problems that require immediate attention? ❑ Yes ❑ No

   If yes please explain_____

7. Do your gums bleed when you brush your teeth?_____

8. Have you noticed any loose teeth?_____

9. Do you clench or grind your teeth? ❑ Yes ❑ No If yes do you wear a Nightguard? ❑ Yes ❑ No

10. Have you been diagnosed with sleep apnea? ❑ Yes ❑ No If yes, do you wear a CPAP mask? ❑ Yes ❑ No

11. Have you ever had orthodontic treatment (Braces or Invisalign)? ❑ Yes ❑ No

12. Are you interested in straightening your teeth? ❑ Yes ❑ No

13. Are you interested in whitening? ❑ Yes ❑ No

14. Are you interested in crowns or implants? ❑ Yes ❑ No

15. Have you ever had any complications or issues with previous dental treatments? ❑ Yes ❑ No

16. Please list anything else not mentioned above regarding your past dental history._____

_____

_____

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PATIENT PRIVACY CONSENT

Consent For Release Of Patient Information

We are committed to protecting the privacy of our patients' personal information and to utilizing personal information in a professional and responsible manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstance in this form, we also collect, use and disclose personal information when permitted or required by the law.
We collect information from our patients such as names, home address, work addresses, home/cellular telephone numbers, work telephone numbers and email 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 collect unpaid accounts.
- To process claims for payment or reimbursement from third party health parties or insurance companies.
- To send reminders to patients concerning the need for further examination or treatment.
- To send patients informational material about our office, dental materials or services offered.
- To follow up with treatment and/or customer service.

How We Collect And Disclose Your Patient Information

Contact information is disclosed to insurance companies, third party health benefit providers where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment and has authorized us to submit a claim on their behalf. Financial information may be collected 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 the patient has asked us to submit a claim on their behalf.
- To other dentists and dental specialists, where seeking a second opinion and the patient has consented to seek a 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 the other dentists and dental specialists where those dentists have asked us, with the consent of the patient to provide a second opinion.
- To the other health care professionals such as physicians if the patient, with their consent, thus been referred to us by the other health care professional for either a second opinion or treatment.

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

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Cancellations & Missed Appointments

We try very hard to accommodate your schedules when booking appointments. This time is reserved just for you and has been scheduled by you. In order to give you the best care possible and to be fair to all our patients and to our team, we ask that you make every effort to keep these appointments. If you are unable to keep your appointment, we ask that you give us at least two business days notification otherwise a fee of $75.00 will apply.

General Release

I, the undersigned, certify that I have provided an accurate and complete personal, medical and dental history, and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform all diagnostic procedures including and not limited to x-rays and photographs, that may be required to determine necessary treatment, and to perform necessary or advisable treatment. I understand that information provided from or to my medical doctor or another healthcare provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that my dental insurance may not cover entirely the total fee of services provided. I understand that I am responsible for payment of the dental services for myself and my dependents, and I assume responsibility for fees associated with these services.

Print Name of Signing Person_____Email of Signing Person_____

Signature_____Date_____

This form was signed by ❑ Patient ❑ Parent ❑ Spouse ❑ Guardian ❑ Other

If other please explain_____