Personal Information

Today's Date _____
Date of Birth _____
Sex: M ○ F ○

Last Name _____ First Name _____
Preferred Name _____ Title: Mr ❑ Mrs ❑ Miss ❑ Ms ❑ Dr ❑
Address _____
_____ Postal Code _____
Phone: Home _____ Work _____ ext. ___ Cell _____
Other_____ Email Address _____
Employer _____ How long there?_____ Occupation_____
Name of Spouse (if Applicable) _____
Emergency Contact in Calgary _____
Please list other family members who are also patients:
_____
How did you find out about our office? _____

Appointment Policy

Confirming appointments

We do not charge for cancelled appointments, but do require 48 hours' notice to change or cancel an appointment. It is our policy to personally confirm your appointment. *Should we not reach you directly, but leave you a message; please return our call to confirm your appointment.*

Please indicate how you would like us to confirm your appointments:
Phone: Home❑ Cell❑ Work❑ Other❑Email: ❑ Best time:_____ Day:_____

Pre-scheduling appointments

In order to provide you with your desired time and date for checkup and cleaning appointments, we are pleased to pre-schedule your appointments. Your hygienist will mail you a post card 3 to 4 weeks prior to the appointment. Please call us whe n you have received your card. We understand that it is often difficult for patients to confirm their appointment 3 to 4 weeks in advance, but ask that you contact us at that time, even if you are unsure about the scheduled appointment. It is our practice to call again, 3-4 days prior to the appointment, to "reconfirm" the time and date.

Insurance Information

Alberta Health Care #_____

Insurance: Please complete if you have insurance coverage
Primary Coverage
Name of Insured Person: _____ Relationship:_____
Private Plan ❑ Employer Plan ❑ Government Plan ❑
Date coverage commenced: _____
Insurance Company: _____
Policy/Coverage Number _____ Division#_____
Certificate Number _____
Name and Phone Number of Personnel Contact at Employer _____
Please list all dependents covered under this plan:
_____
Are there any insurance limitations we should be aware of?
_____

Secondary Coverage
Name of Insured Person: _____ Relationship:_____
Private Plan ❑ Employer Plan ❑ Government Plan ❑
Date coverage commenced: _____
Insurance Company: _____
Policy/Coverage Number _____ Division#_____
Certificate Number _____
Name and Phone Number of Personnel Contact at Employer _____
Please list all dependents covered under this plan:
_____
Are there any insurance limitations we should be aware of?
_____

Medical History

Are you currently undergoing any medical treatment? Yes ❑ No ❑
If yes, please specify

Family Doctor Name _____ Phone # _____
Date of last complete medical exam: _____ Doctor _____
Date of last medical appointment: _____ Doctor _____
Medical specialists seen in past 3 years:

If your activities are currently limited by health problems, please describe:

Has your health changed in the last 12 months? Yes ❑ No ❑
List all drugs/medications, including aspirin, over-the-counter, supplements, or herbs, you are currently taking and the medical condition being treated, if relevant:
Anticoagulants: Yes ❑ No ❑ Drugs for Osteoporosis: Yes ❑ No ❑

Name	Dose/Frequency	Reason for Taking

Please list any allergies: Antibiotics ❑ Latex ❑ Metals ❑ Food ❑ Other ❑
Explain:_____
If you have ever been hospitalized for illness or surgery please give the date and the reason:

Do you play any contact sports? No ❑ Yes ❑_____
Do your ankles, feet, or hands swell? No ❑ Yes ❑ _____
Has your weight, appetite, or energy changed dramatically recently? No ❑ Yes ❑
Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?
No ❑ Yes ❑ _____
Do you have frequent severe headaches, earaches, ear/throat infections?
No ❑ Yes ❑ _____
Do you have any hearing difficulties? No ❑ Yes ❑ _____

(Women only)
Are you currently pregnant? Yes ❑ No ❑ Maybe ❑
Are you nursing? Yes ❑ No ❑
Are you taking hormonal contraceptives (birth control)? Yes ❑ No ❑
(Effectiveness may be reduced by prescribed medications)

Do you have or have you ever been treated for: (Check if applicable)
Asthma ❑ Allergies/Hay Fever ❑ Lung Problems ❑ Chronic Bronchitis ❑ COPD ❑
Vertigo ❑ Sinus Problems ❑ Sleep Apnea ❑ Tuberculosis ❑ Glaucoma ❑
Heart Disease ❑ Congenital Heart Disorder ❑ Heart Murmur ❑ Heart Attack ❑
Mitral Valve Prolapse ❑ Stroke ❑ High Blood Pressure ❑ Low Blood Pressure ❑
Heart Surgery ❑ Fainting Spells ❑ Rheumatic Fever ❑ Tachycardia ❑
Irregular Heart Beat ❑ Prosthetic Heart Valve ❑ Pace Maker ❑ Chest pain/Angina ❑
Shortness of Breath ❑ Stent ❑ Diabetes ❑ Kidney Disease/Dialysis ❑ Jaundice ❑
Thyroid Problems ❑ Stomach Ulcers ❑ Liver Disease ❑ Hepatitis ❑
Heart Burn/Acid Reflux ❑ Blood Disorder ❑ Anemia ❑ Abnormal Bleeding/Bruising ❑
Mental/Emotional Disorder ❑ Drug/Alcohol Dependency ❑ Eating Disorder ❑
Anxiety Attacks ❑ Cancer ❑ Chemotherapy ❑ Radiation Therapy ❑ Steroid Therapy ❑
Immune Disorder ❑ Aids/HIV ❑ Multiple Sclerosis ❑ Fibromyalgia ❑ Venereal Disease ❑
Chronic Fatigue Syndrome ❑ Seizures/Epilepsy ❑ Joint Replacement ❑
Arthritis/Rheumatism ❑ Organ Transplant ❑ Osteoporosis ❑ Check if None Applies ❑

If yes, please gives date(s) and explain:

List any serious medical problem/illness you have ever experienced which is not listed above

To the best of your knowledge, are you in good health? Yes ❑ No ❑ _____

Dental History

Have you ever taken or used and had a reaction to the following:

	No	Yes	Reaction		No	Yes	Reaction
Penicillin	☐	☐	☐	Steroids	☐	☐	☐
Amoxicillin	☐	☐	☐	Aspirin	☐	☐	☐
Clindamycin	☐	☐	☐	Codeine	☐	☐	☐
Erythromycin	☐	☐	☐	Sleeping Pills	☐	☐	☐
Tetracycline	☐	☐	☐	Sedatives	☐	☐	☐
Cortisone	☐	☐	☐	Local Anesthetics	☐	☐	☐
Other Antibiotics	☐	☐	☐				

Have you ever been advised to not to take any specific medication?
No ❑ Yes ❑ If yes, please explain: _____

Have you ever been advised by your doctor to take antibiotics before dental treatment?
No ❑ Yes ❑ If yes, please explain: _____

When was your last complete dental examination? _____

When were your last dental x-rays taken? _____

Who was your dentist? _____

How often do you go to the dentist? _____

Why did you change dentists? _____

Have you ever had a negative dental experience? No ❑ Yes ❑
If yes, please describe: _____

Are you tense or nervous during dental visits? No ❑ Moderately ❑ Very ❑ _____

Please describe what aspect causes your anxiety: _____

Are you interested in sedation? _____

Do you wear dentures or partial dentures? No ❑ Yes ❑ Date of placement _____
Do you use denture adhesive creams? No ❑ Yes ❑ _____

Do any of your teeth ache? No ❑ Yes ❑ _____

Do you have any loose teeth? No ❑ Yes ❑ _____

Is food catching between your teeth? No ❑ Yes ❑ _____

Do you notice any clicking or cracking of the jaws in opening/closing? No ❑ Yes ❑

Do you have any pain or tenderness in your jaw? No ❑ Yes ❑ _____

Do you clench or grind your teeth? No ❑ Yes ❑ _____

Do you have any sores in your mouth? No ❑ Yes ❑ _____

Do you experience pain in chewing? No ❑ Yes ❑ _____

Do you have any sensitivity to: Hot ❑ Cold ❑ Sweet ❑ _____

Are you aware of bad breath or bad taste in your mouth? Yes ❑ _____

Are your gums tender or inflamed? No ❑ Yes ❑ _____

Do your gums bleed upon flossing or brushing? No ❑ Yes ❑ _____

Have you ever been diagnosed as having gum/periodontal disease? No ❑ Yes ❑
Do you have a family history of gum/periodontal disease? No ❑ Yes ❑_____

Have you ever had orthodontic treatment? No ❑ Yes ❑ _____

Have you ever had an injury to your neck, head, face or jaw? (Car accident, sports injury, etc.)
No ❑ Yes ❑ _____

Do you snore? No ❑ Yes ❑

Do you wear a splint for grinding/bruxism? No ❑ Yes ❑ _____

Do you use smoke or use tobacco? No ❑ Yes ❑ Amount _____

Are you wearing a transdermal nicotine patch? No ❑ Yes ❑ _____

Do you use any street drugs? No ❑ Yes ❑ _____

What are your dental needs?

	Short Term	Long Term	N/A	Unsure
Check-up/cleaning	☐	☐	☐	☐
Relieve pain/tooth ache	☐	☐	☐	☐
Periodontal (gum) problems	☐	☐	☐	☐
Broken tooth	☐	☐	☐	☐
Lost fillings	☐	☐	☐	☐
Cosmetic dentistry	☐	☐	☐	☐
Whitening teeth	☐	☐	☐	☐
Veneers/Crowns	☐	☐	☐	☐
Replace missing teeth	☐	☐	☐	☐
New dentures	☐	☐	☐	☐
Dental implants	☐	☐	☐	☐
Sedation	☐	☐	☐	☐

Do you have any specific problems or concerns you would like our office to address?

Personal Information and Financial Consent Policy

Payments for dental services are due at the appointment. Where Insurance benefits are ascertainable and assignment is allowed, we are pleased to accept payment from the Insurance Company.

I understand that not all fees and or procedures will be covered by any dental Insurance plan. These amounts, which include, but are not limited to, co-insurance amounts, deductibles, differences in fee guides, limitations on procedures, such as scaling and exams, are the patient's responsibility and must be paid at the appointment. In many cases we are unable to determine Insurance benefits/limitations until we receive Insurance proceeds. Patients can always obtain coverage information from their Insurance Company, and we will always assist in any way possible.

I assign dental benefits for claims submitted by Ewart Dental and accordingly authorize full payment of all claims to said dental office. Should the Insurance Company direct payment which I had assigned to the dental office, to me, I undertake to forward the proceeds forthwith to Ewart Dental and to not convert the proceeds to any other use.

Amounts not paid by the Insurance Company within 30 days of the service date will be charged back to the patient and payable forthwith.

Overdue accounts are charged interest at 2% per month of 24% per year. Accounts which are in default will be referred out for collection purposes and the patient agrees to pay all costs and penalties incurred therein.

If upon receipt of Insurance proceeds there proves to be a balance unpaid, we require authorization to charge the same to a credit card (Our office will call prior to charging your card).

Personal Information Privacy Policy

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. (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 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 or 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 to 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.

I authorize Ewart Dental to communicate on behalf of myself and all dependents named on my Insurance plan, with my Insurance company and or plan administrator with which I may at any time have coverage. I authorize release of personal/financial/dental/medical information to the same.

Consent

I hereby certify that the medical and dental history is accurate and complete, to the best of my knowledge. I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics or any drugs as indicated and I will assume responsibility for all fees associated with those procedures. My signature on this form authorizes submission, including electronic submission and direct assignment, where allowed, for claims for dental services provided. I consent to the collection, use and disclosure of personal information as described herein.

I have read the foregoing and agree to the terms and conditions stated herein.

_____ _____

Patient's Signature Date