ORCHARDS DENTAL
CLINIC

Patient Name: _____

WELCOME TO OUR DENTAL CLINIC

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.
- 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.

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 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 seeking 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, has been referred to us by the other health care professional for either a second opinion or treatment.

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of regulatory activities in public interest.
I consent to collection, disclosure and use of my personal information as set out above.

Signature of Patient:_____ **Date:** _____

Signature of Guardian/Responsible Party (if under 18 years of age): _____

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Date _____

The information that is requested on this Questionnaire, Dental History and Medical History is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. **Please Print.**

REGISTRATION INFORMATION

The patient is an (circle): Adult | Child | Adult under Guardianship

Name of Guardian: _____

Patient Name: _____I prefer to be called:_____

[ ] Male [ ] Female

Birth date: _____ Age: _____ AHC # _____

Home Address: _____
City_____Prov____Postal Code_____
HomePhone:(____)_____Work: (____) _____ ext. ___ Cell: (____) _____

E-mail Address: _____

Check preferred contact: Telephone home___cell ___work___ Text___or Email __

Employer: _____ Occupation: _____

PERSON RESPONSIBLE FOR ACCOUNT [ ] Same as above
Name:_____ Birth date:___/___/___ Relation: _____
BillingAddress:_____City_____Prov____Postal Code_____
HomePhone:(____)_____Work:(____)_____Cell:( )_____
Employer's Address:_____City_____Prov____ Postal Code_____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co Name:_____ Group/Policy#:_____
Insured'sName:_____Insured'sBirthdate:___/___/_____ (day/month/year)

Relation:_____ ID/Certificate or Employee#_____

Insured's Employer:_____

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Secondary Insurance

Name:_____Phone:(____)_____Group/Policy#_____ Insured's Name: _____Insured's Birth date: ___/___/___ Relation: _____ D M YR
ID/Certificate or Employee#_____Insured's Employer: _____

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 2 business days or 48 hours notice if they cannot keep an appointment.

Appointment changes with less than 2 days notice may be subject to a service fee based on the number of staff members and the amount of time that was reserved for you.

FINANCIAL POLICY

A Direct Billing Agreement must be signed and on file (see direct billing agreement).

Payment Options

For your convenience we accept Cash, Debit, Visa, MasterCard, American Express for outstanding balances. For Patients with Dental Insurance Dental insurance, plans often pay less than the actual fee for service, therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. You are ultimately responsible for all costs incurred regardless of what your dental insurance covers!

Balances in excess of 30 days are subject to a finance charge of 2% per month (24% per annum). Returned checks are subject to a $25 accounting fee.

MEDICAL HISTORY

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Full name: _____ Preferred name/Nickname: _____ Age: _____
Name of Physician/and their specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:		
☐aspirin, ibuprofen, acetaminophen, codeine		
☐penicillin		
☐erythromycin		
☐tetracycline		
☐sulfa		
☐local anesthetic		
☐fluoride		
☐metals (nickel, gold, silver, _____)		
☐latex		
☐nuts _____		
☐fruit _____		
☐other _____		
3. heart problems or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR >3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing/sleep problems (i.e. sleep apnea, snoring, sinus)_	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c=_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25 digestive or eating disorders (eg. celiac, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (ie. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (ie. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) ____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type _____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (ie. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco_	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may possibly affect your dental treatment (ie. Botox, collagen injections).

_____

_____

List all medications, supplements, and or vitamins taken within the last two years.

DENTAL HISTORY

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Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATION CHANGES.

Patient's Signature _____ Date: _____
Doctor's Signature _____ Date: _____

Full name: _____ Preferred name/Nickname: _____ Referred by: _____
Previous Dentist _____ How long have you been a patient _____Months/years
Date of most recent dental exam ____/____ (month/year) Date of most recent x-rays ____/____ (month/year)
Date of most recent treatment (other than a cleaning) ____/____ (month/year)
I routinely see a dentist every: □ 3 months □ 4 months □ 6 months □ 12 months □ not routinely
How would you rate the condition of your mouth? □ Excellent □ Good □ Fair □ Poor
WHAT IS YOUR IMMEDIATE CONCERN?_____
_____

How did you hear about Orchards Dental?
_____

Personal History	Yes	No
1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)? _____	□	□
2. Have you had an unfavorable dental experience? _____	□	□
3. Have you ever had complications from past dental treatment? _____	□	□
4. Have you ever had trouble getting numb or had any reactions to dental anesthetic? _____	□	□
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	□	□
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	□	□
Gums and Bone	Yes	No
7. Do your gums bleed or are they painful when brushing or flossing? _____	□	□
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	□	□
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	□	□
10. Is there anyone with a history of periodontal disease (gum disease) in your family? _____	□	□
11. Have you ever experienced gum recession? _____	□	□
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	□	□
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	□	□
Tooth Structure	Yes	No
14. Have you had any cavities in the past 3 years? _____	□	□
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	□	□
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	□	□

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17. Are your teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?_____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you often get food caught between any teeth? _____	☐	☐

Bite and Jaw Joint	Yes	No
21. Do you have any problems with your jaw joint (pain, sounds, limited opening, locking, popping)? _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. Have your teeth changed (become shorter, thinner, or worn) in the past 5 years? _____	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26. Are your teeth developing spaces or becoming more loose? _____	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? _	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore? _____	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? __	☐	☐
32. Do you wear or have you ever worn a bite appliance? _____	☐	☐

Smile Characteristics	Yes	No
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____	☐	☐
34. Have you ever whitened (bleached) your teeth? _____	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36. Have you been disappointed with the appearance of previous dental work? _____	☐	☐
37. Are you interested in straightening your teeth? _____	☐	☐

Airway	Yes	No
38. Has anyone observed you stop breathing or choking or gasping during your sleep? _____	☐	☐
39. Do you snore in your sleep? _____	☐	☐
40. Do you often feel tired or sleepy or fatigued during the day? _____	☐	☐
41. Do you use a CPAP machine? _____	☐	☐

Patient's Signature _____ Date: _____
Doctor's Signature _____ Date: _____

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DIRECT BILLING AGREEMENT

PATIENT/FAMILY NAME: _____ DATE: _____

With the introduction of the new Health Privacy Act and the diversity of dental benefits packages, more and more dentists are not accepting insurance as payment. It is difficult to maintain accounts with a zero balance because of difficulty in estimating what your insurance payment will be. It has been time consuming and difficult for us to continually collect or refund balances remaining, after insurance payments are received. We would rather invest our time ensuring that optimal dental care is given.

We would like to be able to continue to offer our new and existing patients flexibility in paying for dental treatment with the following options – PLEASE CHECK WHICH OPTION YOU WANT:

- ○ **OPTION 1 – DIRECT BILLING**

Our Direct Billing Program allows us to continue to offer you the courtesy and convenience of using your insurance plan as a form of direct payment. Your insurance will be billed for treatment fees and eligible payment will be sent directly to our clinic. Any balance not covered by your insurance plan will be your responsibility to pay.

- ○ **OPTION 2 – FEE FOR SERVICE**

This option allows you to be in control of your insurance benefits, by paying in full at each appointment for treatment and being reimbursed directly by your insurance company. This will enable you to keep personal records of all dental transactions, all insurance reimbursements, track maximum allowable benefits and you will be more aware of what your plan does and does not cover. You will not have to worry about outstanding balances with us. When insurance companies are reimbursing patients, payment usually takes one to weeks to be received. If your plan accepts electronic dental claims, payment is generally much faster. We will send electronic claims for you at each appointment.

Patient Agreement: I agree to the FINANCIAL RESPONSIBILITY for the following: Account Balance

I, _____ , authorize Orchards Dental to keep my signature on file and issue a charge to my credit card account for my account balance once my insurance portion has been collected. I will be notified by phone or email if any charge is in access of $100.00. I give permission for any claim not paid by my insurance company within 30 days, to be automatically put through on my credit card. A courtesy call/email and receipt will be sent to you with an account statement.

Payment by (circle one): VISA MASTERCARD AMERICAN EXPRESS

CREDIT CARD NUMBER: _____ EXPIRY DATE: _____ CVC: _____

Name on Card: _____ Signature:_____

I do not have a credit card, but I have permission for ORCHARDS DENTAL to use a family member or spouse's card.

Relationship to this person: _____ Their phone number: _____
Credit Card information provided above. **If you do not have a Credit Card to place on file, Option 2 automatically applies ***