



**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):** \_\_\_\_\_



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: \_\_\_\_\_

**Secondary Insurance**

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Group/Policy# \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Birth date: (d/m/y) \_\_\_\_/\_\_\_\_/\_\_\_\_

Relation: \_\_\_\_\_ 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.

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

<b>DO YOU HAVE or HAVE YOU EVER HAD:</b>	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (ie. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic or bad reaction to any of the following:			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			28. autoimmune disease _____ (ie. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			29. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa			32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> nuts _____			37. STI/STD/HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fruit _____			38. hepatitis (type _____)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			39. HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	42. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	43. emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	45. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol/recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>ARE YOU:</b>		
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any illness _____	<input type="checkbox"/>	<input type="checkbox"/>
12. prolonged bleeding due to a slight cut (INR >3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours (ie. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing/sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	53. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	54. considered a touchy/sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	56. taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	57. currently pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	58. diagnosed with a prostate disorder _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c= _____)	<input type="checkbox"/>	<input type="checkbox"/>			
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25 digestive or eating disorders (eg. celiac, gastric reflux, bulimia, anorexia) _____	<input type="checkbox"/>	<input type="checkbox"/>			



# DENTAL HISTORY

## ORCHARDS DENTAL CLINIC

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.

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

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

Patient's Signature \_\_\_\_\_  
Doctor's Signature \_\_\_\_\_

Date: \_\_\_\_\_  
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

- Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)? \_\_\_\_\_  Yes  No
- Have you had an unfavorable dental experience? \_\_\_\_\_  Yes  No
- Have you ever had complications from past dental treatment? \_\_\_\_\_  Yes  No
- Have you ever had trouble getting numb or had any reactions to dental anesthetic? \_\_\_\_\_  Yes  No
- Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? \_\_\_\_\_  Yes  No
- Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? \_\_\_\_\_  Yes  No

### Gums and Bone Yes No

- Do your gums bleed or are they painful when brushing or flossing? \_\_\_\_\_  Yes  No
- Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_  Yes  No
- Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_  Yes  No
- Is there anyone with a history of periodontal disease (gum disease) in your family? \_\_\_\_\_  Yes  No
- Have you ever experienced gum recession? \_\_\_\_\_  Yes  No
- Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_  Yes  No
- Have you experienced a burning or painful sensation in your mouth not related to your teeth? \_\_\_\_\_  Yes  No

### Tooth Structure Yes No

- Have you had any cavities in the past 3 years? \_\_\_\_\_  Yes  No
- Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_  Yes  No
- Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_  Yes  No
- Are your teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? \_\_\_\_\_  Yes  No
- Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_  Yes  No
- Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_  Yes  No
- Do you often get food caught between any teeth? \_\_\_\_\_  Yes  No

### Bite and Jaw Joint Yes No

- Do you have any problems with your jaw joint (pain, sounds, limited opening, locking, popping)? \_\_\_\_\_  Yes  No
- Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? \_\_\_\_\_  Yes  No
- Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? \_\_\_\_\_  Yes  No
- Have your teeth changed (become shorter, thinner, or worn) in the past 5 years? \_\_\_\_\_  Yes  No
- Are your teeth becoming more crooked, crowded, or overlapped? \_\_\_\_\_  Yes  No
- Are your teeth developing spaces or becoming more loose? \_\_\_\_\_  Yes  No



ORCHARDS DENTAL  
CLINIC

- 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. How do you rate your quality of sleep? 1-10 (10 being great)
  
- 42. Has anyone in your immediate family been diagnosed with obstructive sleep apnea?
- 43. Do you use a CPAP machine?
- 44. Have you ever been prescribed a CPAP machine?
- 45. If yes, are you currently using it?
- 46. Do you want to replace your CPAP with an oral appliance?

Patient's Signature \_\_\_\_\_

Date: \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

Date: \_\_\_\_\_



## 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 excess 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.



ORCHARDS DENTAL  
CLINIC

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 \***