PATIENT INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide your dental services.

Patient name: _____ Date of Birth: _____ Sex: _____ Age: _____

Home Address: _____ City: _____ Province: _____ PC: ____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Name of previous dentist: _____ Date of last visit to a dentist: _____

WHOM MAY WE THANK FOR YOUR REFERRAL: _____

YOUR DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Company name: _____

Subscribers/Policy Holders Name: _____ DOB: _____
Day/Month/Year

Group # _____ ID or CERT # _____

Basic % of Coverage: _____ Major % of Coverage: _____ Maximum Per Year: _____

What restrictions do you have on your dental plan? _____
(i.e. How often is polishing covered? Is fluoride covered? How many units of scaling are covered?)

SECONDARY DENTAL INSURANCE

Company name: _____

Subscribers/Policy Holders Name: _____ DOB: _____
Day/Month/Year

Group # _____ ID or CERT # _____

Basic % of Coverage: _____ Major % of Coverage: _____ Maximum Per Year: _____

What restrictions do you have on your dental plan? _____
(i.e. How often is polishing covered? Is fluoride covered? How many units of scaling are covered?)

INSURANCE

Direct billing is a courtesy we offer to our patients and in order to "Direct Bill" your insurance provider, we require a credit card on file for any outstanding amounts owing after your insurance provider has paid their portion. Outstanding accounts over 60 days will be charged 2% interest monthly. I hereby agree to the Financial Policy of Oasis Smile Dental as outlined above and authorize Oasis Smile Dental to apply any outstanding balance on my account, not covered by my insurance provider, to the credit card listed below.

Payment Options are as Follows:

VISA ☐ **Master Card** ☐

Card #: _____ Expiry Date: _____ CC Security Code: _____

Card Holder's Name as appears on card: _____ Authorized Signature: _____

MEDICAL HEALTH HISTORY

CONFIDENTIAL MEDICAL INFORMATION

Name of Physician: _____

Most recent Examination: _____

Are you currently under the care of physician? Yes ☐ No ☐

If yes, please explain: _____

DO YOU HAVE OR HAVE YOUR EVER HAD? Please check yes or no:

Yes	No	
		Anemia
		Arthritis
		Artificial Joints
		Asthma
		Blood Disease
		Diabetes
		Dizziness
		Epilepsy
		Excessive Bleeding
		Fainting
		Glaucoma
		Head Injury
		Heart Disease
		Heart Murmur
		Hepatitis

Yes	No	
		HIV/AIDS/A.R.C.
		Blood Pressure Problem
		Kidney Disease
		Liver Disease
		Mental Disorders
		Nervous Disorders
		Pace Maker
		Rheumatism
		Sinus Problems
		Stomach Problems
		Stroke
		Ulcers
		Tuberculosis
		Venereal Disease
		Do you smoke or chew tobacco?

ARE YOU ALLERGIC OR HAVE YOU EVERY HAD A REACTION TO THE FOLLOWING?
Please check yes or no:

Yes	No	
		Local Anesthesia (Freezing)
		Penicillin or other Antibiotics
		Codeine, Demerol or other Narcotics
		Metals
		Latex

Please list any current medications, vitamins or supplements.

_____

_____

_____

DENTAL HISTORY

Please check yes or no to the following questions.

Yes	No	
		Are you apprehensive about dental treatment?
		Have you had problems with previous dental treatment?
		Do you gag easily?
		Do you ever wear dentures?
		Does food catch between your teeth?
		Do you have difficulty in chewing your food?
		Do you avoid brushing any part of your mouth because of pain?
		Are your teeth sensitive to cold?
		Are your teeth sensitive to heat?
		Are your teeth sensitive to sweets?
		Are your teeth sensitive to sours?
		Do your gums bleed when you brush or floss?
		Are you a habitual gum chewer?

Yes	No	
		Does the saliva in your mouth seem too little?
		Does the saliva in your mouth seem too much?
		Have you had orthodontic (braces) treatment?
		Would you like to have a straighter teeth?
		Have you ever noticed slow-healing sore in your mouth?
		Do you experience pain when you chew?
		Do you have temporomandibular jaw disorder (TMD)?
		Do you clinch or grind your jaws frequently?
		Are you satisfied with the appearance of your teeth?
		Would you like to have whiter teeth?
		Do you notice an unpleasant taste or odor in your mouth?
		Do you have sleep problems?
		Are you interested in discussing sedation dentistry?

How often does your child brush? _____

How often does your child floss? _____

TREATMENT CONSENT

I, the under signed, authorized London Square Dental to perform any necessary dental services and oral surgery that I may need during my diagnosis and treatment with my informed consent. I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. I also understand that any and all dental services are my sole responsibility and that I should make myself aware of any fees associated with my dental care prior to the treatment.

_____ _____ _____

Signature of Patient/Guardian Print Name Date Office Policy

Your appointment time will be reserved especially for you. If you are unable to keep your scheduled visit we require a minimum 2 business days notification. Advance notice allows our office to see other patients who may have been waiting to see us for needed treatment. We thank you in advance for your consideration. A charge of $50.00 may apply to your account if sufficient notice is not provided.

Dental Office Personal Information Consent Form
Personal Information and Protection Act

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 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 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 materials.
- To follow up with treatment and/or customer service.

Contact information is disclosed to the 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 clients 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 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 option.
- 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 option.
- To other healthcare professionals, such as physicians, if the patient, with their consent, has been referred by us to the other healthcare 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.

_____	_____	_____
Patient/Guardian Name	Signature	Date