SPIRIT RIVER DENTAL

NEW PATIENT REGISTRATION FORM

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care. All information provided is strictly confidential. Our receptionists will be able to assist you with the completion of this form.

CONTACT INFORMATION

THIS PATIENT IS AN: ☐ ADULT ☐ CHILD

FIRST NAME: **LAST NAME:** PREFERRED NAME:

DATE OF BIRTH (MONTH/DAY/YEAR): _____/_____/_____ AGE: _____ SEX: ☐ MALE ☐ FEMALE

MAILING ADDRESS: CITY: POSTAL CODE:

HOME PHONE: OTHER PHONE: E-MAIL:

EMERGENCY CONTACT: RELATIONSHIP: EMERGENCY CONTACT NUMBER:

DENTAL PROFILE

LAST DENTAL VISIT (M/D/Y): PREVIOUS DENTAL OFFICE/DENTIST: WERE X-RAYS TAKEN? ☐ YES ☐ NO

LAST CLEANING (M/D/Y):

REASON FOR TODAY'S VISIT:

SIGNATURE: DATE:

Do your gums bleed when you brush or floss?	☐ YES ☐ NO
Do you wear a complete or partial denture?	☐ Yes ☐ NO
Do you snore?	☐ YES ☐ NO
Have you been tested for sleep apnea?	☐ YES ☐ NO
Does food or floss catch between your teeth?	☐ YES ☐ NO
Do you clench or grind your teeth?	☐ YES ☐ NO
Have you ever had any orthodontic (braces) treatment?	☐ YES ☐ NO
Have you ever had any periodontal (gum) surgery?	☐ YES ☐ NO
Are your teeth sensitive to:	☐ COLD ☐ HOT ☐ BITING

This is to certify that I, undersigned, consent to the performing of the dental and/or oral surgery procedure agreed necessary or advisable, including oral anesthetic sedation as indicated, and I will assume responsibility for all fees associated with these procedures.

MEDICAL HISTORY

NAME OF PHYSICIAN: MOST RECENT MEDICAL EXAMINATION (D/M/Y): WHAT IS YOUR ESTIMATE OF YOUR GENERAL HEALTH?
☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

LIST ALL MEDICATIONS, SUPPLEMENTS, AND/OR VITAMINS TAKEN WITHIN THE LAST TWO YEARS:

DRUG NAME	PURPOSE	DRUG NAME	PURPOSE

1. Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain. ☐ YES ☐ NO ☐ UNSURE

_____

2. Has there been any change in your general health in the past year? If yes, please explain. ☐ YES ☐ NO ☐ UNSURE

_____

3. Do you have any allergies? If yes, please list them using the categories below: ☐ YES ☐ NO ☐ UNSURE

☐ MEDICATIONS:

_____

☐ LATEX/RUBBER PRODUCTS:

_____

☐ OTHER (i.e. hay fever, seasonal/environmental, foods)

_____

4. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. ☐ YES ☐ NO ☐ UNSURE

_____

5. Do you have or have you ever had asthma? ☐ YES ☐ NO ☐ UNSURE

6. Are you taking any bisphosphonates or medication for osteoporosis? (i.e. Fosamax, Actonel, Boniva, Reclast) ☐ YES ☐ NO ☐ UNSURE

7. Do you have or have you ever had any heart or blood pressure problems? ☐ YES ☐ NO ☐ UNSURE

8. Do you have or have you ever had a replacement or a repair of a heart valve, an infection of the heart (infective endocarditis), a heart condition from birth (i.e. congenital heart disease), or a heart transplant? ☐ YES ☐ NO ☐ UNSURE

9. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ☐ YES ☐ NO ☐ UNSURE

10. Have you ever had hepatitis, jaundice, or liver disease? ☐ YES ☐ NO ☐ UNSURE

11. Do you have a bleeding problem or bleeding disorder? ☐ YES ☐ NO ☐ UNSURE

12. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ☐ YES ☐ NO ☐ UNSURE

_____

13. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ cold sores	☐ pacemaker	☐ steroid therapy	☐ seizures
☐ heart attack	☐ hepatitis (type: ___)	☐ lung disease	☐ diabetes	☐ kidney disease
☐ stroke, TIA	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	☐ shortness of breath
☐ heart murmur	☐ HIV/AIDS	☐ arthritis	☐ drug/alcohol/cannabis dependency	☐ osteoporosis

14. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain. ☐ YES ☐ NO ☐ UNSURE

_____

15. Do you smoke or chew tobacco products? ☐ YES ☐ NO ☐ UNSURE

16. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ☐ YES ☐ NO ☐ UNSURE

_____

17. Do you identify as a patient with a disability? If yes, please explain. ☐ YES ☐ NO ☐ UNSURE

_____

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

_____

PROVIDER SIGNATURE: **DATE:**

_____

SPIRIT RIVER DENTAL

PERSONAL INFORMATION CONSENT FORM

We are committed to protecting the privacy of our patient's personal information and to utilizing all personal information in a responsible and professional manner. The document summarizes some of the personal information we collect, use and disclose. In addition to the circumstances described in this form, was 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 cell phone numbers (Collectively referred to as "Contact information").

Contact Information is collected and used for the following purposes:

- To phone patients to remind them of their upcoming dental appointment.
- 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 provides 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 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 a 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 provides 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 use obtaining a second opinion.
- 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 by us on the other health care professional for either a second opinion of 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 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 staff as part of its regulatory activities in the public interest.

DATE: **NAME (PRINT):** **SIGNATURE:**

_____

I consent to the collect, use and disclosure of my personal information as set out above.

SPIRIT RIVER
DENTAL

APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to you and the rest of our patients. In attempt to be consistent with this, we have an **appointment cancellation policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **24 hours** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss your appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this as a missed appointment and the $50.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

We thank you for your patronage.

DATE: **NAME (PRINT):** **SIGNATURE:**

_____

I have read and understand the appointment cancellation policy of the practice of Spirit River Dental and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.