Signature SMILES
Suite 201, 103 3 Avenue S.W.
High River, Alberta T1V 1M5
ph (403) 603-3364 • fx (403) 603-3286

Patient Registration

All information is confidential.

Last Name: _____ First Name: _____

Preferred Name: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth(D/M/Y): _____ Employer: _____ Marital Status: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ **E-mail**: _____

Parent/Guardian (if applicable): _____ Phone #: _____

Emergency Contact: _____ Phone # _____

Person responsible for account: _____

Whom may we thank for referring you? _____

If you have any dental benefits please present card or numbers to admin team with this form.

Please note: Our office will be pleased to direct bill your insurance company on your behalf. However, Knowledge of your specific insurance coverage and maximums of coverage is your responsibility.

Date: _____ Signature: _____

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Medical History

All information is confidential.

Health problems you may have, or medication you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following pertinent questions truthfully.

Patient Name:_____ Date of Birth:_____

Physician's Name:_____ Physician's Phone #:_____

Preferred Pharmacy:_____

1. Are you presently, or have you recently been under the care of a physician for any condition or serious ailment? NO YES Please explain:_____
   _____
2. Have you ever had a serious illness or accident requiring hospitalization or extensive medical care? NO YES Please specify:_____
   _____
3. Has there been any change in your general health in the past year? NO YES please explain: _____
4. Do you have any conditions or undergoing any therapies that could affect your immune system? (i.e. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? NO YES
   _____
5. Do you have a bleeding disorder or are you on blood thinners? NO YES
   _____
6. Do you have or have you ever had a replacement or repair of heart valve, heart transplant, an infection of the heart (i.e. Infective endocarditis) or a heart condition from birth (i.e. Congenital heart disease)? NO YES
   Please specify: _____
7. Do you have any prosthetic or artificial joints? NO YES _____
8. Have you ever been told you require antibiotics prior to dental treatment? NO YES
   _____
9. Do you smoke or chew tobacco products? NO If YES, for how many years:_____

10. Do you use any prescription, non-prescription, or recreational drugs/medications? If so, please list below.

Drug_____Reason_____Drug_____Reason_____
Drug_____Reason_____Drug_____Reason_____

11. Have you ever experienced any unusual or allergic reaction to any of the following?

Local anaesthesia Sulfa Drugs Latex/Rubber Aspirin(ASA)
Erythromycin Barbiturates Penicillin Metal(nickel) Codeine

12. Do you have or have you ever had any of the following? (Please circle those applicable)

Fainting or dizziness	HIV positive/testing	Back Problems
Malignant hyperthermia	Mental/nervous disorder	Heart attack/Stroke
Kidney/liver disease	High/Low Blood pressure	Thyroid disease
Hepatitis A,B or C	Stomach/intestinal problems	Diabetes
Organ/Medical implants	Hyperglycemia/hypoglycemia	Epilepsy/Seizures
Drug/Alcohol addiction	Pacemaker/implanted defibrillator	

13. Do you have any other disease, condition or problem that you think the doctor should know about? NO YES
Please explain:_____

14. Women only: Taking Birth Control pills Nursing Pregnant what month?_____

PATIENT (GUARDIAN) CONSENT AND APPROVAL

I, the undersigned, certify that all of the medical and dental information is true to my knowledge and I have not omitted any pertinent information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary and consent to my physician being contacted if necessary.

Patient Signature (or guardian)_____**Date(D/M/Y)**_____

Medical history reviewed and updated:_____Date(D/M/Y)_____
Medical history reviewed and updated:_____Date(D/M/Y)_____

Dental Office Personal Information Consent Form

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 process claims for payment or reimbursement from third party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for the 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 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 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 by 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 consent to the collection, use and disclosure of my personal information as set out above.

Date	Print Name (patient, parent or guardian)	Signature (patient, parent or guardian)

Signature Smiles
Account and Payment Policy

For patients in good standing, with the exception of non-residents or patients with out-of-province insurance, this office will accept assignment of benefits from our patients' insurance carriers for dental services provided.

For the exceptions listed above full payment for each appointment must be provided on the date of the appointment. If applicable a claim will be processed for those individuals so that they may receive reimbursement from their insurance carrier.

Most insurance claims are now sent electronically, not requiring a patient's signature. For those claims that cannot be sent electronically, it is the patient's responsibility to ensure all paperwork is completed and signed.

The patient portion owing on the claim must be paid on the date of the appointment when the insurance carrier provides that information on an electronic claim response.

When an electronic claim does not provide the patient portion owing on the claim or, if a claim cannot be sent electronically, the following will apply:

1. The patient portion owing will be estimated at 20% of all claims generally considered "basic" and is payable on the date of the appointment.

2. The patient portion owing will be estimated at 50% of all claims generally considered "major" and is payable on the date of the appointment.

3. If the patient portion owing has been underestimated, a statement for the balance owing will be mailed and is payable within 30 days of the statement date.

4. If the patient portion owing has been overestimated, the balance will be held as a credit on account and applied towards future appointments. Should the credit exceed $25 the patient will be notified.

All insurance payments must be provided within 45 days. If the insurance carrier does not provide payment within 45 days, the patient is responsible for the payment and must seek reimbursement from their insurance carrier.

Patients who do not have insurance coverage or who have insurance carriers who do not honour assignment, must provide full payment on the date of the appointment.

Personal Insurance Coverage
Our fee schedule is based on the Alberta Dental Association 1997 fee schedule with inflationary adjustments.

Individual insurance policies vary in regards to personal coverage and fee schedule guidelines. It is the patient's responsibility for all knowledge regarding their personal coverage. Preauthorization's for specific dental services will be sent to the insurance carrier when requested by the patient.

Cancellation Policy
48 hours notice is required for cancellation of all appointments except under special circumstances. A **$50.00** cancellation fee may be charged if special circumstances do not apply.

I have read, understood, and agree to the above terms.

_____ Date: _____
(Patient/Parent or Guardian signature)