Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-mail: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #
City Province Postal Code

Health Information

Do you have, or have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ **Latex Allergy**
- ☐ **Medication Allergies:**
  - Penicillin: ☐
  - Codeine: ☐
  - Other:_____
- ☐ Other Allergies: _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ MS
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ **Heart Murmur**
- ☐ Hepatitis: **A B C**
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders:
  - ☐ Depression
  - ☐ Anxiety
  - ☐ Antidepressant

  Medication:_____
- ☐ Pacemaker
- ☐ **Pregnancy**
  Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ **Rheumatic Fever**
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Medication for Osteoporosis:_____

In Office Use Only

- ☐ ASA I
- ☐ ASA II
- ☐ ASA III
- ☐ ASA IV

- Are you currently taking any prescription and/or over the counter medications? Please list any medications, supplements, and or vitamins taken in the last two years:

Drug	Purpose	Drug	Purpose

- Do you have a history/or do you currently smoke and/or use tobacco products? Please list:_____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____

- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____

- Name of Physician: _____ Phone: _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Consent for Services

Direct Billing

Due to the Canadian Personal Privacy Act we are unable to access any sufficient information from your insurance company regarding your dental plan. It is **your responsibility** to know the details involved in your plan such as annual maximums, frequencies and procedure eligibility; you are solely responsible to keep track of how much you've used per 12 months, calendar or benefit year. We extend the **courtesy to bill your insurance** directly, however to avoid any patient portion discrepancies please be fully aware of the particulars of your plan so you can utilize your benefits to their maximum. **Copperfield Dental** can also provide estimates when requested so you may budget your finances accordingly.

Copperfield Dental is pleased to offer you the following payment options. Please **CIRCLE** which option you would like to participate in.

Option A Payment is due in full the day treatment is rendered. We accept Cash, Visa, Debit, MasterCard and American Express. **Copperfield Dental** will process your payment on the date treatment is rendered. Our treatment coordinator will assist you in submitting the necessary documents to your insurance carrier and the insurance cheque will be sent directly to you, the patient.

Option B You will be required to leave your credit card number on file and we will direct bill your insurance company. Any outstanding amounts will be applied to your credit card on file once your insurance company has paid us their portion.
If we receive an explanation of covered costs from your insurance company at the time of your visit you will be required to pay the outstanding balance before you leave.

Cancellation Policy

To ensure our patients are given equal opportunity to book we require confirmation. If you need to change or cancel an appointment please give us at least 48 hours notice. Short notice cancellations and no shows may result in a $50-$100 fee that will be assessed and associated to your account. In the rare event there is a pattern of missed appointments we will only book same day appointments.

PLEASE REVIEW YOUR DENTAL PLAN VERY CAREFULLY TO ENSURE YOU UNDERSTAND THE EXCLUSIONS AND LIMITIATIONS OF YOUR PLAN.

I understand that the fee estimate listed for my dental care can only be extended for a period of six months from the date of the examination.

The fee estimate can change during the course of an appointment. We will do our best to inform you of any changes to allow you to make an informed decision on your course of treatment. However any fee changes that occur are the sole responsibility of the patient.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information I have provided.

I understand that the information provided above will be used to send email/text appointment reminders, confirmations and promotions through Confirm By Email. I consent to my initial photo being taken for my chart (only for staff members to see).

I acknowledge that no guarantee has been made by anyone regarding the dental treatment by which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to having dental treatment provided by Copperfield Dental and realize the risks and limitations.

I certify that I have read or had read to me the contents of this form, filled in completely and accurately to the best of my knowledge and understand the office policies of Copperfield Dental.

X _____ Date: _____

Relationship to Patient: _____

(Signature of patient, parent or guardian)

OPTION B Only

I, _____have chosen **Option B** and hereby authorize any balances outstanding which is not covered by my dental insurance to be automatically applied to:

Credit Card **(circle one):** Visa MasterCard American Express

Card Number: _____-_____-_____-_____

Expiry Date: _____(mm/yyyy)

CVS #: _____

Name **(as it appears on card)**: _____

Signature of Cardholder: _____

Receipts will be emailed to the following address: (if requested) **Email:** _____

Dental Office Personal Information

We are committed to protecting the privacy of our patients 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 address, work addresses, home telephone numbers, work telephone numbers, and e-mail.

- To open and update files.
- To invoice patients for dental services, to process payments.
- To send reminders to patients.
- To send patients information material about our practice.

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement on the patient's behalf.

Patient medical history:

- 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 dental treatment or has asked us to submit a claim on the patient behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patients has consented to us obtaining the 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 professionals.

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 purchasers safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College which may inspect our record 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	Signature