



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: _____
D/M/Y
Home Address: _____ City: _____ Prov: _____ 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? _____
(ie. 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? _____
(ie. 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 Prograce Dental as outlined above and authorize Prograce 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 a physician? Yes No

If yes, please explain: _____

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

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS/A.R.C.
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure Problems (HBP/LBP)
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or chew tobacco?

ARE YOU ALLERGIC OR HAVE YOU EVER HAD A REACTION TO THE FOLLOWING?

Please check yes or no:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetic (Freezing) Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	or other Antibiotics Codeine,
<input type="checkbox"/>	<input type="checkbox"/>	Demerol or other Narcotics Metals
<input type="checkbox"/>	<input type="checkbox"/>	Latex

Please list any current medications, vitamins or supplements.

DENTAL HISTORY

Please check yes or no to the following questions.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Does the saliva in your mouth seem too little?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Does the saliva in your mouth seem too much?
<input type="checkbox"/>	<input type="checkbox"/>	Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had orthodontic (braces) treatment?
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Would you like to have straighter teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever noticed slow-healing sore in your mouth?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience pain when you chew?
<input type="checkbox"/>	<input type="checkbox"/>	Do you avoid brushing any part of your mouth because of pain?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have temporomandibular jaw disorder (TMD)?
<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to cold?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your jaws frequently?
<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to heat?	<input type="checkbox"/>	<input type="checkbox"/>	Are you satisfied with the appearance of your teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to sweets?	<input type="checkbox"/>	<input type="checkbox"/>	Would you like to have whiter teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to sour?	<input type="checkbox"/>	<input type="checkbox"/>	Do you notice an unpleasant taste or odor in your mouth?
<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sleep problems?
<input type="checkbox"/>	<input type="checkbox"/>	Are you a habitual gum chewer?	<input type="checkbox"/>	<input type="checkbox"/>	Are you interested in discussing sedation dentistry?

How often do you brush? _____

How often do you floss? _____

TREATMENT CONSENT

I, the under signed, authorize Prograce 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 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 of 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 & 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 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 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 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 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