NORTHERN HILLS DENTAL™
A.Nathu Professional Corporation

CONFIDENTIAL PATIENT RECORD

Patient ______________________________
Surname First Middle

Date of Birth ______________________ Age ______________________
Day Month Year

Address ______________________________

City ______________ Postal ______________ Email ______________

Home Phone ______________ Work ______________ Cell ______________

Occupation ______________ Employer ______________

Family Doctor ______________ Phone ______________ Emerg. Contact ______________

How did you hear about us? (circle) Postcard Walk By (big sign) Yellow Pages Website
Northern Edge Newsletter (community) ______________
Other (please specify) ______________

DENTAL INSURANCE INFORMATION

Insurance Company #1 ______________
Policy/Group # ______________
ID # ______________
Policy Holder's Name ______________
Policy Holder's Birth date ______________
Policy Holder's Employer ______________

Insurance Company #2 ______________
Policy/Group # ______________
ID # ______________
Policy Holder's Name ______________
Policy Holder's Birth date ______________
Policy Holder's Employer ______________

MEDICAL HISTORY

1. Are you currently in good health? ☐yes ☐ no
   If no, please explain ______________
2. Are you currently taking any medications or vitamins (prescription, over-the-counter, recreational)? ☐yes ☐ no
   If yes, please list ______________
3. Do you currently smoke? ☐yes ☐ no If yes, for how long______________
4. Are you allergic to or ever had a reaction to any of the following: (please circle)
   Penicillin Local Anesthetic ("freezing") Sulfa Drugs
   Codeine Aspirin (ASA) Other ______________
5. Are you under the regular care of a physician? ☐yes ☐ no
   If yes, please explain ______________
6. Do you bleed more or longer than normal after a cut, bruise, surgery or previous tooth removal? ☐yes ☐ no
7. Have you ever had a serious illness or operation? ☐yes ☐ no
8. Do you currently have or ever had any of the following conditions? (please circle)
   Heart Trouble or Stroke Heart Murmur Thyroid Disorder Rheumatic Fever
   Breathing Problems Arthritis HIV Positive Tumors or Cancer
   High/Low Blood Pressure Hepatitis Liver Disease Kidney Disease
   Mental Illness Diabetes Tuberculosis Epilepsy or Seizure
   Blood Disorders Venereal Disease Hormonal Disorder Other: ______________
9. Women: Are you pregnant? ☐yes ☐ no If yes, which trimester? ______________
10. Is there anything else we should know about your health? ☐yes ☐ no
    If yes, please explain ______________

DENTAL HISTORY

11. What dental condition(s) concern you at present? ______________
12. When was your last dental check-up and cleaning? ______________
13. Were X-rays taken at your last dental visit? ☐yes ☐ no
14. When was the last time you changed **dental offices**? ______________
15. Have you noticed any signs of the following? (please circle)
    Bleeding Gums Swelling of Gums Gum Ache Receding Gums Loose Teeth Drifting of Teeth
16. Do you have any clicking, popping or pain in your jaw joint? ☐yes ☐ no
17. Are you aware of clenching or grinding your teeth? ☐yes ☐ no
18. Do you have any missing teeth that you feel should be replaced? ☐yes ☐ no
19. Would you like to improve the appearance of your teeth? ☐yes ☐ no
20. Do you floss your teeth? ☐yes ☐ no How often?______________
21. Have you had any complications or difficulty with previous dental treatment? ☐yes ☐ no
22. How do you rate yourself as a dental patient? ☐ Calm ☐ Slightly Nervous ☐ Very Anxious

I hereby certify that the Medical and Dental Histories provided are accurate and complete to the best of my knowledge. I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic or any drugs as indicated and I will assume responsibility for fees associated with those procedures.

Date ______________ Signature ______________

OFFICE POLICIES

NORTHERN HILLS DENTAL™

APPOINTMENT REMINDERS

Please understand that it is **your responsibility** to keep track of your appointments. We will do everything we can to remind you of them in adequate time for you to make arrangements or changes for that appointment.

CANCELLATIONS

Due to a continuous high demand in prime appointment times, we require a **minimum of 24 hours notice** per appointment should you require to reschedule your appointment (48 hours notice for Monday appointment times). This is valuable time that the Dentist/Hygienist has reserved for you. In the case that insufficient notice is given a **$55.00 fee** will be charged to you.

SQUEAKY CLEAN CLUB (child patients ONLY)

All children under the age of 10, who get any service done at our office can have his/her picture taken & added to the Squeaky Clean Club wall of pictures. It gives children a sense of pride & accomplishment, while aiding in making other children feel important, special & relaxed when they see pictures of children they know. If this pertains to your child(ren) your child's first name & approx. age will be listed on the picture. This is not a mandatory program; if you do not want your child's picture taken please notify the staff.

DIRECT BILLING INSURANCE & PAYMENT ARRANGEMENTS

The Canadian Personal Privacy Act prohibits us from accessing any information from your insurance carrier. It is **your responsibility** to know the details involved in your plan (annual maximums, frequencies, other limitations). We extend the **courtesy to bill your insurance** directly, however, to avoid any discrepancies please be fully aware of the particulars of your plan so you can utilize your benefits to the maximum & request a pre-determination be submitted to your insurance company for any major treatment planned. This will give you an estimate of what your insurance will pay for that treatment prior to getting the work done.

Below are 2 payment options available to you. Please **circle** which option you would like to participate in.

OPTION 1 — Payment is due **in full** on the day treatment is completed. We accept cash, Debit, Visa, MasterCard & American Express. Your payment will be processed & insurance documents will be generated for you to submit to your insurance carrier. An insurance cheque will be sent directly to you from your insurance carrier.

OPTION 2 — We will direct bill your insurance carrier. You will be require to leave a credit card number on file & any outstanding amount will be applied to that credit card once your insurance carrier has paid us its portion. A receipt for payment will be mailed to you. If we receive an explanation of benefits from your insurance carrier after your visit, you will be required to pay the outstanding balance before you leave.

FEE INCREASES

Each January, our office will increase fees to keep in line with insurance carrier increases. Any estimate (pre-determination) for treatment prior to January 1st will be recognized until March 1st of the New Year, after that any outstanding treatment estimates will be increased to follow the current year's fees.

I have read & understood the above policies.

_______________________________   ____________________

Patient/Guardian Signature   Date

OPTION 2 ONLY

I hereby authorize any outstanding balances not covered by my insurance carrier to be automatically applied to:

Credit Card (circle one): Visa MasterCard American Express

Card #:_______/_____/_____/_____ Expiry Date: _________(mm/yr) Name (on credit card): ______________________

Signature of Cardholder: ______________________________

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NORTHERN HILLS DENTAL™

Privacy Policy

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, cellular phone numbers and email addresses (collectively referred to as "Patient Contact information"). Patient 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 for third-party health benefits providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment.
- To send patients information material about our dental practice.

Patient 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 will be collected in order to make arrangements for the payment of dental services provided, unless the dental services are paid for in full at the time of visit.

We collect information from our patients about their health history, their family health history, physical condition, and previous 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 is 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.
- *www.northernhillsdental.com* and any electronic submissions through this site allow us access to personal information such as, email addresses, IP addresses, names, phone numbers and dental requirements. Website information is collected and used for the purpose of booking/revising appointments.

If information is no longer required, all pertinent documents are destroyed using the services of Shred-It, an on-site, secure document destruction program developed specifically to deal with regulatory privacy and confidentiality requirements.

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	Signature

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