Welcome To Memorial Square Dental

PATIENT REGISTRATION & HEALTH HISTORY *MEDICAL ALERT*

Last Name: First Name: Birthdate: Female( ) Male( )

Address:

City: Province: Postal Code:

Home # ( ) Cell #( ) Work #( )

Alberta Health Card#

Who may we thank for referring you? Google, Website, Facebook, Sign, Community Newsletter, Other:

Health History:

1. Have you had a medical examination in the last year?----------Yes / No
2. Have you been a patient in the hospital during the past two years?----------Yes / No
3. Please state your physician's name:_____ Phone: _____
4. Have you ever been advised to take antibiotic premedication before dental appointments? YES/NO
5. Please list all the medications you are on now: _____

5. For WOMEN only: Are you pregnant? YES / NO If yes, what month _____
6. Are you taking birth control pills? YES / NO

Are you allergic or have you reacted to any of the following medications? Please CIRCLE:

Acetaminophen (Tylenol)	Demerol	Lorazepam (Ativan)	Percocet
Aspirin	Diazepam (Valium)	Nitrous Oxide	Sleeping Pills
Codeine	Erythromycin	Novocain	Triazolam (Halcion)
Clindamycin	Local Anesthetic	Penicillin	Other Antibiotics

Are you aware of being allergic to any other medications or substances? YES / NO If yes, which one:

Please let us know if you have or have had any of this illnesses. Please CIRCLE:

AIDS	Cortisone/Steroid Meds	Hemophilia	Radiation/Chemotherapy
Allergies/Hives	Diabetes	Hepatitis A/B/C	Scoliosis
Angina Pectoris	Drug Addiction	Herpes	Scarlet Fever (Back Problems)
Anemia	Emphysema	High or low blood pressure	Sickle Cell Disorder
Artificial Heart Valve	Epilepsy/Seizures	HIV Positive	Sinus Trouble
Artificial Joints	Fainting/Dizzy Spells	Kidney Trouble	Stomach Problems
Arthritis/Rheumatism	Fever Blisters	Liver Disease	Stroke
Asthma	Glaucoma	Lung Disease	Thyroid Disease
Blood Disorders	Hay Fever	Mitral Valve Prolapse	Tuberculosis (TB)
Bruise Easily	Heart Disease/Attack	Organ Transplant	Ulcers
Cancer	Heart Failure/Murmur	Persistent Cough	Undiagnosed Skin Rash
Cold Sores	Heart Pacemaker	Persistent Diarrhea	Venereal Disease
Congenital Heart Lesions	Heart Surgery	Psychiatric Disorders	Yellow Jaundice

If you have any disease, condition or problem not mentioned above, please list:

Dental History:

1. Have you had regular dental exams in the past?	YES / NO	11. Do you notice bad breath?	YES / NO
2. When was your last dental visit?		12. Have you ever experienced headaches upon awakening?	YES / NO
3. What was done?			
4.Have you ever had abnormal bleeding or other problems associated with previous dental extractions or surgery?	YES / NO	13.Do you Smoke? / If so, how many?	YES / NO
		14. Are you happy with the appearance of your teeth?	YES / NO
5. Have you ever had any complications with local anesthetic (freezing)?	YES / NO	15. have you ever had professional dental hygiene instruction on brushing and flossing?	YES / NO
6. Are you having dental pain?	YES / NO	16. Do you brush daily?	YES / NO
7. Have you noticed loosening teeth?	YES / NO	17. Do you floss daily?	YES / NO
8. Have you noticed food catching between your teeth?	YES / NO	18. Do your gums bleed when brushing?	YES / NO
9. Do you have pain/swelling of gums?	YES / NO	19. Do your gums bleed when flossing?	YES / NO
10. Do you have any oral habits such as clenching or grinding, nail biting or sucking your thumb?	YES / NO	20. Do your gums bleed spontaneously?	YES / NO

This is to certify that I, _____ consent to the performing of the dental and oral surgery procedures agreed to be necessary or advised, including the use of local anesthetics as indicated and I will assume responsibility for fees associated with those procedures including those fees which are not covered by any insurance I may be covered by at any given time I agree that the information pertaining to my health to be true to the best of my knowledge at this time.

Signature _____ Dated _____ Parent ( ) Guardian ( )

(please mark "X" which one applies)

PERSONAL INFORMATION

Last Name_____ First Name_____

Emergency Contact:_____ Telephone:_____

Relationship:_____

SCHEDULED APPOINTMENTS

Please know that appointment times have been reserved for you, and any change in the schedule affects many people. If for any reason you are unable to keep the reserved appointment time, we ask the courtesy of two business days' notice to allow us to offer the time to another patient who may be waiting. Broken appointments cancelled with less than two business days' notice may be subject to a broken appointment fee. _____ (initial)

ONLINE COMMUNICATION SYSTEM

We invite you to participate in our online system. Features include: requesting appointments online, receiving reminders by email or text message, confirmation of appointments by email, patient satisfaction surveys and special event news. I agree to provide my email address for contact purposes and understand I can choose my settings and unsubscribe at any time.

EMAIL:_____

Signature:_____ Dated:_____

FEES/PAYMENT

I understand that I am fully responsible for the total fee at the time of service and I have chosen to assign my benefits, payable from claims submitted electronically to Memorial Square Dental and acknowledge that the patient portion (or estimated patient portion) is due at the time of service

Signature:_____ Dated:_____

CREDIT CARD AUTHORIZATION (OPTIONAL)

I consent to the use of the below credit card on file for the payment of any outstanding balances.

_____ _____ _____

Card Number Exp Date SEC Code

Signature:_____ Dated:_____

Dental Benefit Information

Primary Insurance

Subscriber Name:	**Date of birth:**	
Insurance Carrier:		
Group/Contract Number:		
ID/Certificate Number:		
Relationship to subscriber: self spouse child other		
Anniversary Date:	Xray Frequency: Panorex	Bitewings:
Maximums:	Recall Frequency: 6M, 9M, 12M	
Fee Guide:	# of scaling units:	Polish/Fluoride:
Deductibles:	Are frequencies calendar year or rolling:	

Secondary Insurance

Subscriber Name:	**Date of birth:**	
Insurance Carrier:		
Group/Contract Number:		
ID/Certificate Number:		
Relationship to subscriber: self spouse child other		
Anniversary Date:	Xray Frequency: Panorex	Bitewings:
Maximums:	Recall Frequency: 6M, 9M, 12M	
Fee Guide:	# of scaling units:	Polish/Fluoride:
Deductibles:	Are frequencies calendar year or rolling:	

Other Insurance (if applicable)

Subscriber Name:	**Date of birth:**	
Insurance Carrier:		
Group/Contract Number:		
ID/Certificate Number:		
Relationship to subscriber: self spouse child other		
Anniversary Date:	Xray Frequency: Panorex	Bitewings:
Maximums:	Recall Frequency: 6M, 9M, 12M	
Fee Guide:	# of scaling units:	Polish/Fluoride:
Deductibles:	Are frequencies calendar year or rolling:	

ASSIGNMENT OF INSURANCE BENEFITS/FEES & PAYMENT

Your dental insurance is a benefit designed to assist you in maintaining your oral health and is not designed to dictate the treatment and quality of care you and your family receive. As a courtesy to you we can bill most dental insurance plans directly and do expect payment of the patient portion (or estimated patient portion) payable at the time of service. Making us aware of your dental coverage will assist us in answering questions you may have about treatment we recommend. Please be aware that we are unable to collect detailed insurance information on behalf of patients due to privacy policies. It is important that you provide us with as much up to date insurance coverage information as possible. This information may be found in a benefit booklet, online website, or through you HR department

ELECTRONIC CLAIM AUTHORIZATION

I understand that Memorial Square Dental has invested in the technology to submit my claims electronically and I authorize release, to my benefit carrier and the CDA, information contained in claims electronically. I also authorize the communication of information related to the coverage of dental services.

Signature:_____ Dated:_____

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. 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 number, work telephone number 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 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 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.

Patient's 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 their 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 out 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 the necessary 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.

_____	_____	_____
Signature	Printed Name	Dated