VEGREVILLE FAMILY DENTAL

6615 Hwy 16A West, Vegreville, AB T9C- 0A3 Tel: 780-639-3912

PERSONAL HISTORY

Name _____ Date of Birth:_____
Last First Initial day month year

Single □ Married □ Child □ Other □ Who referred you?_____

Address_____ City_____ Postal Code_____

Home Phone_____ Business Phone_____ Ext____

Cell_____ E-mail_____

Family Physician_____ Telephone_____

Emergency Contact_____ Emergency Number_____

Insurance Information

Primary Insurance Information

Name of Insured_____ DOB_____

Name of Insurance Company_____ Policy#_____ ID#_____

Secondary Insurance Information

Name of Insured_____ DOB_____

Name of Insurance Company_____ Policy# _____ ID#_____

Health History

Have you ever had any of the following? Please check those that apply:

- ❑ AIDS/HIV Positive
- ❑ Anemia
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Autoimmune
- ❑ Cancer
- ❑ Chronic fatigue
- ❑ Congestive heart failure
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fibromyalgia
- ❑ Fainting
- ❑ Frequent Diarrhea
- ❑ Frequent sore throats
- ❑ Gastro esophageal reflux disease (GERD)
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay fever
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart murmur
- ❑ Heart beating or pounding irregularly
- ❑ Nervous Disorders
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Heart valve replacement
- ❑ Heartburn or sour taste in the mouth at night
- ❑ Hepatitis_____
- ❑ High Blood pressure
- ❑ Low Blood pressure
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorder
- ❑ Migraines
- ❑ Muscle spasms
- ❑ Pacemaker
- ❑ Persistent Cough
- ❑ Poor circulation
- ❑ Pregnant
- ❑ Radiation Treatment
- ❑ Rheumatic fever
- ❑ Rheumatism
- ❑ Sinus problems

- ❑ Stomach Problems
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Thyroid problems
- ❑ Tumors
- ❑ Ulcers
- ❑ Undiagnosed Skin Rash
- ❑ Venereal Disease

Other Medical History:_____

_____

Health History Continued:

List any medication that may have caused an allergic reaction:_____

_____

List any medication you are currently taking:_____

_____

What dental concerns do you have at present?_____

_____

When was the last dentist/ dental hygiene appointment you've had?

_____

Consent of Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of 3 months from the date of the patients' examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time of payment. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suite be instituted hereunder.

I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

_____ _____ _____

Signature of patient, parent or guardian Date: Relationship to patient

Vegreville Family Dental

6615 Hwy 16A West, Vegreville, AB T9C 0A3
780 639 3912

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 we collect, use and disclose. In additions 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, email addresses, home telephone numbers, work telephone numbers, and cell phone numbers (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 information on 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 of the payment of dental services.

We collect information from our patients about their health history, their family health history, physical conditions, and dental treatments (Collectively referred to as "Medical Information"). Patient's 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 our has asked us to submit a claim on the patient's behalf.
- To other dentists and dental specialist, 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 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	Signature