



PATIENT INFORMATION

Name: _____ Date of Birth: _____

Primary Phone #: _____ Street Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Employer or School: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____ Relationship: _____

How did you find out about our office? Door hanger Safeway Road sign

Google Facebook Drove by Family/Friend referral: _____

MEDICAL INFORMATION

YES NO

Have you had a recent exposure to any communicable infectious diseases? (Measles, Chicken Pox or Tuberculosis)

In the last 24 hours have you had: a new cough, shortness of breath, fever, chills, diarrhea or any flu-like symptoms?

Have you previously been or are currently under the care of a health care professional for any kind of specific condition or syndrome?

Do you require premedication prior to hygiene (cleaning) appointments, or dental treatment?

Have you ever had any major surgeries?

If yes, please list: _____

Do you have any known allergies?

If yes, please list: _____

Are you taking any medications (including birth control, vitamins, etc.)?

If yes, please list: _____

(Females) Are you pregnant, nursing, or is there a **possibility** you could be pregnant?

Please check any of the following below that you have **ever** had a bad reaction to:

- Local Anesthetics Codeine Insulin Ibuprofen Latex Metals: _____
- Barbiturates Penicillin Aspirin Iodine Other: _____

Approximate Height: _____ Approximate Weight: _____ (for sedation and medication purposes only)

Do you have, or have you ever had any of the following?

	YES	NO		YES	NO
Anemia or Low Iron (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (year: _____)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina or Chest Pain (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (Rheumatoid or Osteo, circle)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Artificial/Prosthetic Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, or C (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure/Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots or Stroke (circle)	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS Positive	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Liver Disease (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Blood Condition (type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Bleed Easily	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (year & type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker (date placed: _____)	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Pins/Plates	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia or Pleurisy (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defect/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder/Illness	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (Type I or Type II, circle)	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Drug or Alcohol Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema or COPD (circle)	<input type="checkbox"/>	<input type="checkbox"/>	Smoke/Smokeless Tobacco/Vape	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid or Adrenal Condition (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Eye Disorders/Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis/TB	<input type="checkbox"/>	<input type="checkbox"/>

Please list any disease, condition, or illness that was not listed: _____

DENTAL INFORMATION

Approximately when was your last dental check-up/cleaning? _____

How often do you visit the dentist? _____

How often do you brush your teeth? _____ Floss your teeth? _____

Are you having any problems that require immediate attention? If yes, please explain: _____

Do any of the following cause tooth discomfort? Sweets Hot Cold Chewing

	YES	NO
Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic treatment (Braces or Invisalign?)	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in straightening your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have spaces you would like closed?	<input type="checkbox"/>	<input type="checkbox"/>

Please add anything you feel is important we should know: _____

DENTAL INFORMATION

Benefit/Insurance Coverage? YES NO

Secondary Insurance (if applicable)

Policy holder name: _____

Policy holder date of birth: _____

Insurance company or carrier: _____

Group or Policy #: _____

ID or Certificate #: _____

Employer: _____

I authorize release to my dental benefits plan administrator and the CDA information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Signature: _____ Date: _____

I hereby assign my benefits, payable from claims submitted electronically, to Cornerstone Family Dental and authorize payment directly to them. This authorization shall continue in effect until the undersigned revokes the same.

Signature: _____ Date: _____

As you may know, your individual benefit provider may only cover a percentage of the total fee of services provided. Therefore, we may require a credit card number to accept assignment from your insurance carrier. This is with the understanding that our office manager may be calling you for authorization to use this credit card to pay the difference not paid by your insurance provider. This can occur because dental fees are based on factors such fee guides or maximums, which may or may not have been considered by your employer when enrolling in your individual plan.

I have read the above and agree to assume full responsibility for all fees, amounts, or copay not covered by my individual dental benefit provider. I understand that Cornerstone Family Dental may help to provide the most accurate estimate possible, but it is ultimately the patient's responsibility to know what their dental benefit coverage details are.

Signature: _____ Date: _____

I understand that Cornerstone Family Dental requires me to give **48 hours notice** prior to cancelling or rescheduling an appointment, and that if I fail to do so, a \$50 fee may apply. As a courtesy, our office will provide a reminder call, or send an email or text reminder to you. If you choose to opt out of this automated communication, please let our office know.

Signature: _____ Date: _____

Here at Cornerstone Family Dental, we will do our best to help you with the transfer of x-rays, and/or any relevant dental records from a previous office. However, situations may arise where the transfer of your records is delayed, or the x-rays on file are outdated. If on the day of your exam we do not have the appropriate x-rays from your old office, or the most current x-rays are outdated, then we will need to take new ones (in most cases we will consider any x-rays more than 1 years old outdated). We therefore encourage patients to contact our office at least 1 day prior to their appointment to verify that we have received the records from your previous office. **Please note:** occasionally the quality of x-rays from a previous office is not of appropriate diagnostic value, or the resolution of images gets sacrificed during the digital transfer from office to office. At the discretion of the Dentist, we may need to take new x-rays even if you have had x-rays taken recently. We do not charge for such x-rays as long as the previous office x-rays are not outdated. These are taken to aid our Dentists in performing a quality diagnostic dental exam.

PRIVACY INFORMATION

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 for dental purposes. In addition to the circumstances described in this form we may also collect, use, and disclose personal information when permitted or required by law.

We collect information from our patient such as names, home addresses, work telephone numbers, home telephone number, cell phone numbers and email addresses (collectively referred to as "Contact Information"). 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. Contact Information is collected and used for the following purposes:

- To open and update patient files
- To invoice patient 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 patients information material about our dental practice

Financial Information may be collected and used for the following purposes:

- To aid in the arrangement of payment for dental services

We collect information from our patients about their medical history, health conditions, physical condition, and dental treatment (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. 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 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 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 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 a prospective purchaser safeguards all personal information.

Dentists are regulated by the **Alberta Dental Association & College**, and the **Canadian Dental Association** which may inspect our records and/or interview our staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of this personal information for myself (or as the guardian of), as set out above.

Signature: Date: