CORNERSTONE FAMILY
DENTAL

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? ☐ Live in area ☐ Drove by ☐ Road sign ☐ Door hanger ☐ Magazine

☐ Google ☐ Facebook ☐ Safeway ☐ Radio ☐ Solea Laser ☐ 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)	☐	☐	Heart Attack (year: _____)	☐	☐
Angina or Chest Pain (circle)	☐	☐	Heart Disease	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐
Arthritis, Rheumatoid or Osteo (circle)	☐	☐	Heart Valve Replacement	☐	☐
Artificial/Prosthetic Joint Replacement	☐	☐	Hepatitis A, B, or C (circle)	☐	☐
Bleed Easily	☐	☐	High Blood Pressure/Hypertension	☐	☐
Blood Clots or Stroke (circle)	☐	☐	HIV/AIDS Positive	☐	☐
Blood Transfusion	☐	☐	Kidney or Liver Disease (circle)	☐	☐
Blood Condition (type: _____)	☐	☐	Low Blood Pressure	☐	☐
Cancer (year & type: _____)	☐	☐	Malignant Hyperthermia	☐	☐
Chemotherapy	☐	☐	Pacemaker (date placed: _____)	☐	☐
Cold Sores	☐	☐	Pins/Plates	☐	☐
Diabetes (Type I or Type II, circle)	☐	☐	Pneumonia or Pleurisy (circle)	☐	☐
Drug or Alcohol Dependency	☐	☐	Psychiatric Disorder/Illness	☐	☐
Emphysema or COPD (circle)	☐	☐	Radiation Therapy	☐	☐
Epilepsy/Seizures	☐	☐	Smoke/Smokeless Tobacco/Vape	☐	☐
Eye Disorders/Glaucoma	☐	☐	Thyroid or Adrenal Condition (circle)	☐	☐
Heart Defect/Disease	☐	☐	Tuberculosis/TB	☐	☐

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?	☐	☐
Have you ever had orthodontic treatment (Braces or Invisalign?)	☐	☐
Are you interested in straightening your teeth?	☐	☐
Do you have spaces you would like closed?	☐	☐

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

_____

DENTAL & BENEFIT INFORMATION

Do you have Benefit/Insurance Coverage that you would like us to direct bill for you? ☐ **YES** ☐ **NO**

	Primary Insurance Information	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 my 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.

PERSONAL INFORMATION PROTECTION & PRIVACY CONSENT

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 the named patient, as set out above.

Signature: _____ Date: _____