INFORMATION & MEDICAL HISTORY FORM

RAINBOW FALLS
DENTAL

PATIENT INFORMATION

NAME_____

Date of Birth: _____ **Today's Date:** _____

Address: _____ City: _____ Postal Code: _____

Home Ph. #: _____ Cell # or Work #: _____

Email: _____

Employer or School: _____

How did you find out about our office?_____

Spouse or Parent's Name: _____

OR Next of Kin (for Emergency Contact): _____ Relationship: _____

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 other 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? **If yes please be sure to take your premedication prior to your appointment.**	☐	☐
Do you currently have or have you ever had a cold sore?	☐	☐
Have you ever had any major surgeries? If yes, please explain: _____	☐	☐
Are you taking any medications (including birth control, vitamins, etc.) If yes, please list: _____	☐	☐
Do you have any known allergies? If yes, please list: _____	☐	☐
(FEMALES) Are you pregnant or nursing, or 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 ☐ Barbiturates ☐ Latex ☐ Metals: _____

☐ Ibuprofen ☐ Penicillin ☐ Aspirin ☐ Iodine ☐ Other: _____

Approximate Height _____Weight_____ (for sedation and medication purposes)

Have you had or do you have any of the following?

	YES	NO		YES	NO
Anemia	☐	☐	Cancer (date:_____)	☐	☐
Stroke or Blood Clots (circle one)	☐	☐	Chemotherapy	☐	☐
Bleeding Easily	☐	☐	Radiation therapy	☐	☐
Blood Transfusions	☐	☐	Hepatitis/Jaundice	☐	☐
Heart Disease	☐	☐	Drug/Alcohol Dependency	☐	☐

	YES	NO		YES	NO
Artificial Heart Valve	☐	☐	Mental Illness	☐	☐
Congenital Heart Defects	☐	☐	HIV	☐	☐
Rheumatic Heart Disease	☐	☐	Heart Murmur	☐	☐
Angina, heart attack, chest pain (circle)	☐	☐	High Blood Pressure	☐	☐
Tuberculosis	☐	☐	Rheumatoid Arthritis	☐	☐
Asthma or Hay Fever (circle one)	☐	☐	Eye disorders	☐	☐
Emphysema	☐	☐	Epilepsy or Seizures (circle one)	☐	☐
Pneumonia or Pleurisy (circle one)	☐	☐	Malignant Hyperthermia	☐	☐
Thyroid/Adrenal Disease	☐	☐	Kidney Disease	☐	☐
Pins, plates, replacement joints(circle)	☐	☐	Diabetes	☐	☐
Pacemaker	☐	☐	Smoker	☐	☐

Do you have any disease, condition, or illness that was not listed?

_____

DENTAL INFORMATION

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?.....	☐	☐
Have you ever considered straightening, bleach, crowns or veneers?	☐	☐
Do you have spaces you would like closed?.....	☐	☐

How do you feel about the appearance of your teeth? _____

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

INSURANCE INFORMATION

Insurance Coverage: ☐ **YES** ☐ **NO** Secondary Insurance (If Applicable)

Policy holder's name: _____ _____

Policy holder's date of birth: _____ _____

Your insurance company/carrier: _____ _____

Group or policy number: _____ _____

I.D./Certificate No.: _____ _____

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 Rainbow Falls Dental and authorize payment directly to them. This authorization shall continue in effect until the undersigned revokes the same.

Signature of subscriber: _____ **Date**: _____

As you may know your insurance covers only a percentage of the total fee of services provided and we therefore require a credit card number to accept assignment from your insurance carrier. This is with the understanding that our office manager will be processing fees under $50.00 automatically to pay the difference not paid by your insurance provider and calling you for authorization to use this credit card for fees over $50.00**. I understand that anything not covered by my dental insurance is my full responsibility to pay. Rainbow Falls Dental may help to provide the most accurate estimate possible, but it is ultimately the patients responsibility to know what their insurance coverage details are.**

Signature:_____**Date**:_____

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

Signature of patient (or Guardian): _____ Date: _____

Here at Rainbow Falls Dental we will do our best to help you with the transfer of x-rays and any records from your previous office. However, situations do 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). Therefore, we 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. Again, our staff will do their best to aid you in this process, but ultimately it is the responsibility of the patient to ensure past dental records get transferred to our office.

Note: Occasionally the quality of x-rays from other offices is not of appropriate diagnostic value. The resolution of images often 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 dental exam

PERSONAL INFORMATION 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. 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 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 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

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 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 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 this personal information for myself _____
or as the guardian of _____, as set out above.

Print Name:_____ Signature: _____ Date: _____

RAINBOW FALLS DENTAL

INSURANCE WORKSHEET

Patient Name: _____ Date: _____

Your particular dental plan may or may not cover the full cost you incur for your necessary dental treatment. This can occur because fees in our office are based on factors and fee guides, which may or may not have been considered by your employer when enrolling in your plan. In addition, there may be certain dental procedures performed which are not covered by your individual policy. **Our office will accept direct payment from your dental plan** for the cost of those dental services we provide that are covered by your individual policy, however, there are many variations of individualized treatment and it is almost impossible for us to know the details of individual policies. With many privacy laws in effect, it prevents us from obtaining detailed information on your behalf regarding your individual coverage. For this reason, we ask for your understanding if we are unable to provide financial details pertaining to your insurance at the time the treatment is recommended by the dentist or dental hygienist. **We will, however, strive to provide the most accurate estimate possible prior to starting treatment.** In order to answer your financial questions there are some basic information from your insurance that we request. We ask that you call your insurance company and ask the questions listed below. We will keep this document on file to better assist you when a member of our dental team is discussing your treatment and fees.

WHAT TO ASK YOUR INSURANCE COMPANY:

1. What is my policy year? _____
2. What percentage of basic dental treatment does my plan cover? _____%
3. What percentage of major dental treatment does my plan cover? _____%
4. What is the maximum benefit that I qualify for each year? $ _____
5. What is your yearly deductible? $ _____
6. Does my plan accept assignment? YES ☐ NO ☐
7. How often am I covered for?

Complete or New Patient Exam:	Code # 01103	_____
Recall or check up exam:	Code # 01202	_____
Polishing:	Code # 11101	_____
Fluoride treatment:	Code # 12101	_____
Bite-wing radiograph:	Code # 02144	_____
Panoramic radiograph:	Code # 02601	_____

8. How many units of scaling (cleaning) am I covered for? Code #11111 _____

   Is it based: ☐ Calendar year? OR ☐ Every rolling 12 months? OR ☐ Policy year?

9. How many units of root planning (deep cleaning) am I covered for?

   Is it based: ☐ Calendar year? OR ☐ Every rolling 12 months? OR ☐ Policy year?

10. Do you have composite (white filling) coverage on molars? YES ☐ NO ☐
11. Do you have implant coverage? YES ☐ NO ☐
12. Do you have Ortho coverage? Age restriction? _____ YES ☐ NO ☐

I have read the above and agree to assume full liability for fees not covered by my insurance plan.

Patient Signature: _____ Date: _____