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| --- | --- |
| **Patient Name** | **Medical Alert** (*Office Use Only*) |

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code \_\_\_\_\_\_\_\_\_\_

Phone # (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex M F Birth Date \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_ Day Month Year

|  |  |
| --- | --- |
| **Adult Patient** | **Child Patient** |
| Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Mother’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Father’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Marital Status M S W D | Person Responsible for account \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**WHOM MAY WE THANK FOR YOUR REFERRAL**: Friend Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Google Yellow Pages Newspaper Flyer Website Other Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you like appointment reminders? Phone  Text  Email

**TREATMENT CONSENT**

I, the under signed, authorize Inglewood Family Dental to perform any necessary dental services and oral surgery that I may need during my diagnosis and treatment with my informed consent. I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. I also understand that any and all dental services are my sole responsibility and that I should make myself aware of any fees associated with my dental care prior to treatment.

Your appointment time will be reserved especially for you. If you are unable to keep your scheduled visit **we require a minimum of 2 business days notification**. Advance notice allows our office to see other patients who may have been waiting to see us for needed treatment. We thank you in advance for your consideration.

Signature of Patient/Guardian Print Name Date

**INSURANCE**

Primary Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Insurance Year End: \_\_\_\_\_\_\_\_\_\_\_ Group/Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID/Certificate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Annual maximum: $\_\_\_\_\_\_\_\_\_\_\_\_ Annual deductible: $\_\_\_\_\_\_\_\_\_\_\_\_\_   
Percentage coverage: Basic: \_\_\_\_\_\_\_\_\_\_% Major: \_\_\_\_\_\_\_\_\_\_\_%

Secondary Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Insurance Year End: \_\_\_\_\_\_\_\_\_\_\_ Group/Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID/Certificate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Annual maximum: $\_\_\_\_\_\_\_\_\_\_\_\_ Annual deductible: $\_\_\_\_\_\_\_\_\_\_\_\_\_   
Percentage coverage: Basic: \_\_\_\_\_\_\_\_\_\_% Major: \_\_\_\_\_\_\_\_\_\_\_%

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| **INSURANCE** |

Direct Billing is a courtesy we offer to our patients and in order to ‘Direct Bill’ your insurance provider,

# Dental Office Personal Information Consent Form Personal Information & Protection Act

We are committed to protecting the privacy of our patients’ 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 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 numbers, work telephone numbers 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 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 informational material about our dental materials.
* To follow up with treatment and/or customer service.

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.

Patients’ Medical Information is disclosed for the following purposes:

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 option.
* 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 healthcare professionals, such as physicians, if the patient, with their consent, has been referred by us to the other healthcare professional for either a second opinion or treatment.

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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Name Signature Date