NEW PATIENT FORM

PERSONAL INFORMATION

- ❏ Male
- ❏ Female

Full Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____

HOW WOULD YOU LIKE TO CONFIRM YOUR APPOINTMENTS? (select below)

- ❏ EMAIL
- ❏ CELL
- ❏ HOME
- ❏ WORK

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
Date of Birth: _____
Emergency Contact (Name/Phone): _____
Employer: _____
Email: _____

How did you hear about our office? (Select one below)

- ❏ Website
- ❏ Social Media
- ❏ Family/Friend
- ❏ Co-Worker
- ❏ Other (please specify): _____

MEDICAL HISTORY

MEDLEY DENTAL CLINIC
because everyone deserves to smile

Family Physician/Doctor Name: Dr. _____Phone #: _____

Have you ever had the following diseases or medical problems? **PLEASE CHECK OFF ANY THAT YOU HAVE HAD IN THE PAST OR PRESENTLY HAVE.**

- ❏ Heart Attack
- ❏ Stroke
- ❏ Heart Disease
- ❏ Ulcers
- ❏ Colitis
- ❏ Crohns
- Artificial Valves
- ❏ Stents/Prostheses
- ❏ Cancer
- Chemotherapy-Date: _____
- ❏ Heart Murmur
- ❏ Rheumatic Fever
- ❏ Anemia Radiation Treatment
- Heart Surgery
- Pacemaker
- ❏ Sexually Transmitted Diseases: _____
- ❏ Congenital Heart Defect
- ❏ Mitral Valve Prolapse
- ❏ HIV Positive
- ❏ AIDS
- ❏ Blood Transfusion
- Sinus Problems
- ❏ Cold Sores
- High Blood Pressure
- ❏ Low Blood Pressure
- ❏ Hemophilia
- ❏ Abnormal Bleeding
- TB Emphysema Asthma
- ❏ Severe Headaches
- ❏ Frequent Headaches
- Kidney Disease
- ❏ Thyroid
- ❏ Drug Abuse
- ❏ Alcohol Abuse
- ❏ Diabetes Type: _____
- ❏ Chewing Tobacco
- Liver Hepatitis: A or B or C
- ❏ Smoker
- ❏ Vaper
- ❏ Knee Hip Ankle Pins Plates
- ❏ Prescription, Marijuana, Cannabis Oil
- ❏ Anxiety Depression
- ❏ Psychiatric Disorder
- ❏ Epilepsy Seizures
- ❏ Fainting Spells
- ❏ Current Persistent Cough
- ❏ Chronic Diarrhea
- ❏ Undiagnosed Skin Rash

Do you have any medical conditions or surgery that requires you to be premedicated prior to dental treatment?
Spefify: _____
Are you taking any oral contraceptives? _____
Are you pregnant? If yes, how many weeks: _____
Jaw Joint Pain Jaw Soreness Jaw click/crack/pop?_____
Any allergies? _____
Please list any medications/herbal supplements or over the counter medications you are currently taking:
_____
Any Other Medical Concerns we should know about? _____

Have you traveled outside of Canada in last 12 months? Date/Location:_____

Are you nervous about or have you had a negative dental experience?_____

Are you happy with your smile?_____

By signing this document you also acknowledge all documents will be digitally converted and archived as such. All documents active or achived in digital format I recognize them as valid legal documents."

Patient/Parent/Guardian Signature: _____ Date: _____

ACKNOWLEDGEMENT OF CANCELATION POLICY

It is our intention, that our appointment times be the most suitable for our patient's personal time and schedule. We will gladly reschedule any appointment to a more convenient time. However, if you change or cancel an appointment with less than 24 hours' notice you could be subject to a cancellation fee of $100.00. _____ INITIALS

INSURANCE INFORMATION

#1 POLICY HOLDER:_____Birthdate:_____

Employer:_____
Insurance
Company:_____Policy#:_____Div/Class:_____ID#:_____
Basic Services_____% Maximum $_____Major Services_____% Maximum
$_____
Recall Frequency_____months / Root Planning/Scaling_____units

#2 POLICY HOLDER:_____Birthdate:_____

Employer:_____
Insurance
Company:_____Policy#:_____Div/Class:_____ID#:_____
Basic Services_____% Maximum $_____Major Services_____% Maximum
$_____
Recall Frequency_____months / Root Planning/Scaling_____units

• As a special service to our patients we are able to bill your insurance company directly for your dental treatment. If you should have any questions in regards your insurance we recommend contacting your insurance company directly. We recommend getting familiar with your dental plan before you treatment in order to eliminate any coverage or reimbursement disappointments.
• Your benefit coverage is a contract between yourself, your employer and the insurance company. Personal plan information is considered “confidential medical information” and such it will not be released to us as your dental provider.
• I have read and fully understand the above conditions and that as a courtesy my insurance plan will be billed. I will pay the patient portion you estimate at each visit, and agree that I am ultimately responsible

for the payment of this office's full dental fees. All unpaid balances over 45 days are automatically billed directly to me.

I ,_____ give Medley Dental Clinic the authorization to charge the balance of my account to my credit card # _____expiry _____/_____
(American Express/Visa/ Mastercard) not to exceed the amount of $50.00 or $100.00 in the event that my insurance company does not pay the full balance left on my account. The amount will automatically be charged to the above number for the sole purpose of dental treatment provided and a receipt will be mailed.

If I do not have dental insurance coverage, I am aware that I am fully responsible for all charges incurred on the day of treatment.

Patient/Parent/Guardian Signature _____Date_____

PERSONAL INFORMATION CONSENT FORM

We are committed to protecting the privacy of our patients' personal information and 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 address, work address, home telephones numbers, work phone 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 information 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 patients' 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.

During treatment, photographs are taken to document certain intra-operative conditions.

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 dentist 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 specialist if the patient, 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 considering selling all or part of our dental practice, qualified potential purchasers may be granted access a 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 interviews staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal information and any dependents as set out above.
DATE _____NAME (PRINT): _____

PATIENT/GUARDIAN SIGNATURE: _____