Montrose DENTAL CARE

Patient's Full Legal Name_____
Preferred First Name_____
Date of Birth (mm/dd/yyyy) _____
Sex Male____ Female____
Marital Status (for insurance purposes)
Single__ Married__ Divorced__ Common Law__ Widowed__ Separated__

Address _____
City _____ Postal Code _____

Contact Information:
Home (____) _____
Cell (____) _____
Work (____) _____
Preferred Contact Home ___ Cell___ Work___
Email address: _____

How would you prefer us to confirm your upcoming appointments?
Phone call ___ Email___ Text___

*****IF YOU HAVE PRIMARY AND/OR SECONDARY INSURANCE, PLEASE BRING THE INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT. *****

Montrose Dental Care
Unit 100 6202-29 Ave Beaumont AB T4X0H5

Patient Consent

I_____, consent to be a patient at Montrose Dental Care. I also understand and consent to the following:

1) I will provide a complete medical history, supply a full list of medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history.

2) I understand that although the dentist and staff do a very detailed comprehensive exam, my treatment plan may change during treatment as the extent of some conditions cannot be known prior to treatment. If a change from the original treatment plan occurs during treatment the dentist or staff will inform me.

3) I understand that any branch of medicine, including dentistry, can involve unanticipated results. As a result, no absolute guarantees can be made about treatment outcomes.

4) I am welcome to ask questions about any aspect of my dental care. I am responsible for clarifying any aspects of my treatment that I am unsure about.

5) I understand that even if an insurance pre-estimate is given or a procedure has been pre-approved, I am responsible for any costs that my insurance does not cover. I am responsible for understanding my insurance policy and do not hold Montrose Dental Care accountable for limitations within my plan. It is my responsibility to deal directly with my insurance company when complications occur.

6) I will give Montrose Dental Care a minimum of 48 hours notice for cancellation of an appointment. If I do not give 48 hours cancellation notice, I understand that my account may be charged a cancellation fee.

Personal Information

We are committed to protecting the privacy of our patient's personal, financial, and medical information.

Patient's contact information is used to:

- Invoice patients for dental services rendered
- Send patient reminders concerning the need for further dental examination or treatment
- Process claims to third party health benefit providers and insurance companies

Patient's medical and dental information is disclosed to:

- Third party health benefit and insurance providers where the patient has submitted a claim for reimbursement
- To other dentists and specialists where we are seeking a second opinion and the patient has consented to us obtaining a second opinion.
- To other dentists or specialists for treatment and the patient has consented to us sending the referral
- To other health care professionals if the patient, with their consent, has been referred to us by other health care professionals for 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.

I consent to the collection, use and disclosure of my personal information as set out above.

_____	_____	_____
Print Name	Patient or Guardian Signature	Date

Montrose Dental Care Financial Policy

***** ONE FORM NEEDED PER FAMILY HOUSEHOLD*****

Montrose Dental Care financial options:

1) Montrose Dental care will direct bill patient insurance companies providing the below credit card authorization form is completed and a valid credit card remains on file. We process insurance claims electronically at the end of the appointment but do not always receive insurance coverage information at that time, thereby rendering us unable to immediately collect your patient portion. Once we receive the insurance portion, cardholders will be emailed a statement indicating any outstanding fees. Your credit card will be charged for the statement amount two business days after the statement is sent, providing we have not received a reply from you in that time. If there are any questions or concerns regarding the charges it will be the patient's responsibility to contact our office within two business days to discuss or clarify. If you wish to make payment by a different method other than the card on file, you may do so by contacting our office and making the appropriate arrangements.

All credit cards on file are stored in a password protected and encrypted software system that complies with Canadian credit card protection laws. Only one staff member has access to this software system. No additional charges will ever be applied to the card unless the cardholder approves and is aware. The fees for treatment will never change after the appointment has been completed. If you wish to have a statement of total fees charged before insurance coverage has been applied, you are welcome to request it.

2) If you do not wish to leave your credit card on file, you are required to pay for the appointment charges at the time of treatment. We will submit the insurance claim on your behalf and have the insurance reimbursement sent directly to you. Insurance reimbursements usually arrive within two to three weeks depending on your insurance company.

I hereby authorize Montrose Dental Care to process any fees, not covered by my insurance plan, to the credit card provided below. This includes fees pertaining to the members of my family as listed below.

Family Members Include:

1) _____2) _____

3) _____4) _____

5) _____6) _____

Card Holder Name: (please print) _____

Card Holder Signature: _____

Signed on the _____ day of _____, 2_____

Email Address for Statement Notifications: _____

Credit Card# (Visa/MC-No Amex): _____

Expiry Date: _____ 3-Digit Security Code on back _____

Medical and Dental History

Patient Name:_____
Physician/Doctors Name:_____ Date of last medical exam:_____
Previous Dentist/Dental Office:_____
Date of last dental exam:_____ Date of last dental x-rays:_____

Dental History

What is your immediate concern:_____

Please answer yes or no to the following (if yes please describe):	YES	NO
1. Are you fearful of dental treatment? How fearful on a scale of 1(least)-10(most)_____	❑	❑
2. Have you ever had complications with previous dental treatment?_____	❑	❑
3. Have you ever had trouble getting numb or had a reaction to local anesthetic?_____	❑	❑
4. Do your gums bleed or are they painful when brushing or flossing?_____	❑	❑
5. Have you ever been treated for gum (periodontal) disease or had a gum graft?_____	❑	❑
6. Are any of your teeth sensitive to hot, cold, biting, sweets, or brushing?_____	❑	❑
7. Do you frequently get food caught between any teeth?_____	❑	❑
8. Do you have problems with your jaw joint? (pain, sounds, popping, locking, limited opening)_____	❑	❑
9. Do you feel like your jaw is being pushed back when you bite your teeth together?_____	❑	❑
10. Do you clench day or night and make your teeth or muscles sore?_____	❑	❑
11. Have you ever worn a bite appliance or night guard?_____	❑	❑
12. Is there anything about the appearance of your teeth you would like to change?_____	❑	❑
13. Do you get headaches or migraines? If yes how often?_____	❑	❑
14. Do you snore or have been treated or diagnosed for sleep apnea?_____	❑	❑

Medical History

Please answer yes or no to the following (if yes please describe or indicate which):

Do you have:	YES	NO
1. An allergic reaction to:		
Aspirin, ibuprofen, acetaminophen, codeine___	❑	❑
Penicillin_____	❑	❑
Erythromycin_____	❑	❑
Sulfa_____	❑	❑
Local anesthetic_____	❑	❑
Fluoride_____	❑	❑
Metals (nickel, gold, silver,_____)___	❑	❑
Latex_____	❑	❑
Other _____		
2. Hospitalization for illness or injury in the last 2 years?_	❑	❑
3. Heart problems or cardiac stent within last 6 months?	❑	❑
4. History of infective endocarditis?_____	❑	❑
5. Artificial heart valve or repaired heart defect?_____	❑	❑
6. A pacemaker or implantable defibrillator?_____	❑	❑
7. Artificial prosthesis (heart valve or joints)?_____	❑	❑
8. Ever had rheumatic or scarlet fever?_____	❑	❑
9. High or low blood pressure (if so which)?_____	❑	❑
10. Had a stroke (taking blood thinners)?_____	❑	❑
11. Anemia or other blood or bleeding disorder?_____	❑	❑
12. Emphysema or shortness of breath?_____	❑	❑
13. Tuberculosis or measles?_____	❑	❑
14. Asthma?_____	❑	❑
15. Breathing or sleep problems (sleep apnea, sinus)?____	❑	❑
16. Kidney disease?_____	❑	❑
17. Liver disease or jaundice?_____	❑	❑
18. Thyroid, parathyroid disease or calcium deficiency?__	❑	❑
19. High cholesterol or taking statin drugs?_____	❑	❑
20. Diabetes (type_____)?_____	❑	❑
21. Stomach or duodenal ulcers?_____	❑	❑
22. Digestive disorders (celiac, gastric reflux)?_____	❑	❑
23. Osteoporosis/osteopenia (taking bisphosphonates?)____	❑	❑
24. Arthritis, rheumatoid arthritis, lupus?_____	❑	❑
25. Glaucoma?_____	❑	❑
26. Head or neck injuries?_____	❑	❑
27. Epilepsy, seizures?_____	❑	❑
28. Viral infections and cold sores?_____	❑	❑
29. Hives, skin rash, hay fever?_____	❑	❑
30. STI or STD?_____	❑	❑
31. Hepatitis (type___)?_____	❑	❑
32. HIV/AIDS?_____	❑	❑
33. Exposed to HPV? (Important for oral cancer screening)	❑	❑
34. Ever had a tumor or abnormal growth?_____	❑	❑
35. Ever had radiation or chemotherapy?_____	❑	❑
36. Immunosuppressive therapy?_____	❑	❑
37. Antidepressant medication_____	❑	❑
38. Psychiatric treatment?_____	❑	❑
39. Street drug use?_____	❑	❑
40. A smoker, previous smoker, or smokeless tobacco?_____	❑	❑
41. FEMALE- pregnant?_____	❑	❑
42. FEMALE- nursing?_____	❑	❑
43. MALE- prostate disorders?_____	❑	❑
44. Being treated for any other illness?_____	❑	❑
45. Family history of heart disease?_____	❑	❑
46. Family history of diabetes?_____	❑	❑
47. Family history of periodontitis?_____	❑	❑

Please describe any other current medical treatment or condition that may affect your dental treatment:_____

List all medications, supplements, and vitamins taken:

Drug	Purpose	Drug	Purpose	Drug	Purpose
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	

Patient/Guardian Signature_____ Date_____