



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) _____

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

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

Card Holder Name: (please print) _____

Card Holder Signature: _____

Today's Date: _____

Email Address for Statement Notifications: _____

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) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had complications with previous dental treatment? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had trouble getting numb or had a reaction to local anesthetic? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do your gums bleed or are they painful when brushing or flossing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been treated for gum (periodontal) disease or had a gum graft? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are any of your teeth sensitive to hot, cold, biting, sweets, or brushing? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you frequently get food caught between any teeth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have problems with your jaw joint? (pain, sounds, popping, locking, limited opening) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you feel like your jaw is being pushed back when you bite your teeth together? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you clench day or night and make your teeth or muscles sore? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever worn a bite appliance or night guard? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Is there anything about the appearance of your teeth you would like to change? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you get headaches or migraines? If yes how often? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you snore or have been treated or diagnosed for sleep apnea? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Medical History

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

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

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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient/Guardian Signature _____ Date _____