CORINTHIA DENTAL

REGISTRATION INFORMATION (please print)

Title: Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Marital Status: ___________________ Male ☐ Female ☐

(Last Name) (First Name) (Initial)

(Address) (City) (Province) (Postal code)

Date of Birth: ______ / ______ / ______
Month Day Year

Mobile Phone: ( ) ______________________
Home Phone: ( ) ______________________
Work Phone: ( ) ______________________

E-mail address: ____

Emergency contact: _____________________________ Phone Number: ______________________

Physician: _____________________________________ Phone Number: ______________________

Occupation: ___________________________________

Employer: _____________________________________

How did you hear about our office? ____

MEDICAL HISTORY

1. Have you ever had a serious illness or condition requiring hospitalization or extensive medical care?
   If yes, please specify: ____
2. Are you presently under the care of a physician?
   Please specify: ____
3. Do you take any prescription or non-prescription medications currently?
   If yes, please specify: ____

4. Indicate which of the following you presently have or ever had: (Please check all that applies)

☐ Anemia ☐ Cold Sores ☐ Heart Disease ☐ Lung Disease
☐ Angina ☐ Cortisone/Steroids ☐ Heart Murmur ☐ Mental/Nervous Disorder
☐ Arthritis/Rheumatism ☐ Diabetes ☐ Hepatitis A/B/C ☐ STD's
☐ Asthma ☐ Emphysema ☐ High/Low Blood Pressure ☐ Sinus Problems
☐ Artificial Heart Valve ☐ Epilepsy/Seizures ☐ HIV ☐ Stomach Problems/Ulcers
☐ Artificial Joint ☐ Fainting ☐ Hyper/Hypo Glycemia ☐ Stroke
☐ Blood Disorders ☐ Glaucoma ☐ Kidney Disease ☐ Thyroid Disease
☐ Cancer ☐ Heart Attack ☐ Liver Disease ☐ Other: ________________

5. Do you have AIDS or have your tested positive for HIV? ☐ Yes ☐ No
6. Do you have any of the following? ☐ Asthma ☐ Hay Fever ☐ Food Allergies ☐ Metal or Latex allergies ☐ Skin Rashes
☐ Hives ☐ Other Allergic Conditions: ____
7. Are you allergic or have you ever reacted adversely to any of the following: ☐ Penicillin ☐ Keflex ☐ Sulfa Drugs
☐ Other Antibiotics ☐ Local anesthesia ☐ Codeine ☐ Aspirin ☐ Other Medications
Please explain: ____
8. Do you bruise easily or bleed abnormally? ☐ Yes ☐ No
9. Do you have any blood disorders such as anemia or taking blood thinners? ☐ Yes ☐ No

10. Have you ever had any injury, surgery or radiation therapy to your face, head, or neck? ☐ Yes ☐ No
If yes, please specify:____

11. Do you have a tendency to faint? ☐ Yes ☐ No

12. Do you suffer from severe headaches? ☐ Yes ☐ No

13. Have you had any organ transplants or medical implants? ☐ Yes ☐ No
If yes, please indicate: ____

14. WOMEN ONLY: Are you currently pregnant or suspect you may be? ☐ Yes ☐ No
If yes, how many weeks? ________________________

15. WOMEN ONLY: Are you taking birth control pills? ☐ Yes ☐ No

16. Do you have any other medical conditions not listed you would like to notify us of? ☐ Yes ☐ No
If yes, please explain: ____

DENTAL HISTORY

1. Date of last dental visit: __________________________ Previous Dental Clinic or Dentist: _________________________________

2. Are there any dental conditions that concern you at present?
If yes, please describe: ____

3. How often do you brush your teeth? _______________

4. How often do you floss your teeth? ________________

5. Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Eating and Chewing

6. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never

7. Do you have any of the following oral habits? ☐Clenching ☐ Grinding ☐ Nail biting ☐ Cheek or lip biting ☐ Mouth breathing

8. Have you experienced any of the following jaw problems? ☐ Popping/click of Jaw Joint ☐ Pain in Jaw Joint ☐ Difficulty in opening and closing

9. Are you missing any teeth? ☐ Yes ☐ No If so, have they been replaced? ☐ Yes ☐ No If not, would you like them replaced? ☐ Yes ☐ No

10. Do you smoke? ☐ Yes ☐ No
If yes, how many years have you smoked? ________________ How many per day? _______________

11. How nervous do you feel coming to the dentist (scale of 1-5): Not at all 1 2 3 4 5 Very

12. Do you have any present concerns regarding your smile, teeth or gums?
____

PATIENT CERTIFICATION AND CONSENT

I, THE UNDERSIGNED, CERTIFY THAT THE ENTIRE ABOVE MEDICAL AND DENTAL INFORMATION IS TRUE TO MY KNOWLEDGE AND I HAVE NOT KNOWLY OMITTED ANY INFORMATION. I GRANT THE RIGHT OF THE DENTIST TO RELEASE HEALTH INFORMATION OBTAINED FROM ME, AND INFORMATION ABOUT MY DENTAL TREATMENT TO THIRD PARTY PAYERS, AND OTHER HEALTHCARE PROVIDERS. I CONSENT TO THE PERFORMING OF DIAGNOSTIC, DENTAL, AND ORAL SURGERY PROCEDURES AS AGREED TO BE NECESSARY OR ADVISED AND I WILL ASSUME RESPONSIBILITY FOR THE FEES ASSOCIATED WITH THESE PROCEDURES, REGARDLESS OF DENTAL INSURANCE.

____ ________________________

Patient/Parent/Guardian Signature Date

Personal Information Consent Form (Privacy 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 described 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 email addresses (collectively referred to as "Contact Information").
<u>Contact Information</u> 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 practice.

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"). Patient's Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.
Patient's <u>Medical Information</u> 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 my personal information as set out above.

________________	______________________________	______________________________
Date	*Print Name*	*Signature*

CORINTHIA
DENTAL

DENTAL INSURANCE:

Excellent dental care is available with or without dental benefits; however, if you have dental benefits, as a courtesy to our patients, we will file your charges to your insurance carrier on your behalf if a valid credit card is left on your personal file. Any differences not covered from your benefits will be required to be paid on the date of service or charged to your credit card. Since the Privacy Act has been passed, some insurance companies will only release information/payments to the insured member and not to the dental office, therefore; any claims not paid from your insurance carrier after 30 days from date of service will be charged to your credit card.

It is the insured person's responsibility to understand their benefits as our staff are unable to keep track of all the individual details of each plan. Every plan is different, and the contract is still between yourself, your employer and your insurance carrier. Our team members will gladly assist you in completing the necessary forms to maximize your dental benefits and discuss your financial options.

I hereby assign my benefits payable, from claims submitted electronically or otherwise, to Dr. Michael Quong and authorize payment directly to him.

(Signature) ________________________________

______ VISA ______ M/C

CARD# ____

EXP DATE __________________________ (MM/YR)

SIGNATURE OF CARDHOLDER: ______________________________________

CANCELLATION POLICY:

We respect our patient's time. For this reason, we would like to advise you that your appointments are reserved to meet both you and your family's needs. The length of your appointment is based on your individual treatment. Please respect the time we have reserved for you. If you find that the appointment time that we have scheduled requires change, ***please note that we ask that you provide us with 2 Business days' notice***. *If less than 48 hours notice is given, a cancellation fee of $50.00 - $100.00 will apply.*

I have read, understand and accept the terms of the above outlined policies for insurance and financial commitments that may occur.

Name (please print) ____

Signature____ Date_____________________

We thank you for your cooperation, and look forward to providing exceptional care for you and your family.

CORINTHIA
DENTAL