# *Welcome to Petrolia Dental!*

*Thank you for choosing our office. We strive to provide you the most gentle, quality dental care possible. If you have any questions, or we can help you in any way, please feel free to ask any team member.*

## *Patient Information:*

Name: ______________________________________________________________________________
Last name First Name Initial

(If child, parent/guardians names)______________________________________________________

Birth date______________________ Gender:_________ Age:_______
Day/Month/Year

Home Address___________________________________ City__________________ Prov_______ Postal Code__________

Home Phone:_____________________ Work Phone___________________________ Cellphone_______________________

Email______________________________________________ **May we contact you by email?**_________________________

Employer______________________ Occupation_______________ How long there?_______ May we call you there?______

Spouse's Name (or other parent/guardian)___________________________________ Cell phone_______________________

**If patient is a student**: Name of College/School__________________________ City/Pr___________ full or part time?_____

**How did you hear about our practice?** ❑ brochure in mail ❑yellow pages ❑community newsletter ❑website/internet ❑walk/drive by ❑referred by friend ❑referred by a staff member of Petrolia Dental ❑other _______________

**Who should we thank for referring you?**______________________________________________________

***In Case of Emergency***

Name of Primary Care Physician_______________________________________ Phone Number__________________________

Someone we may contact in an emergency ______________________________ Contact Number_______________________

***Authorization:***

I authorize my insurance company to make payment directly to the dental office for benefits otherwise payable to me (if assignment of insurance option chosen on Financial Arrangement Form). I authorize release of my records to third party payers, other healthcare professionals, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions. I have received a copy of this office's Privacy Practices.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card for any unpaid balances, including those after insurance payments. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form and it is accurate to the best of my knowledge.

**Signature**__________________________________________________ **Date**_________________________________

**Patient or Responsible Party**

# Petrolia Dental - Dental History

**Reason for Seeking Care Today** _ ___ Exam ____ Cleaning ____ Specific Problem________________________________
Please describe

***Please check all that apply:***

| | | | |
|---|---|---|---|
| ❑Toothache | ❑Bite or teeth have shifted | ❑cracked, chapped lips | ❑unable to open wide |
| ❑Broken filling or tooth | ❑Often bite cheeks | ❑bad taste in mouth | ❑jaws get tired easily |
| ❑Sensitivity to: | ❑dry mouth | ❑sinus problems | ❑hold things between teeth (pipe, pencil, nails, pins) |
| ❑cold | ❑concerned about breath | ❑mouth breath – difficulty breathing through nose | ❑bite fingernails |
| ❑hot | ❑unhappy with previous dental work | ❑dry or strained eyes | ❑unusual habits with teeth |
| ❑sweets | ❑gums bleed | ❑shoulder, neck or headaches | ❑wore braces |
| ❑chewing | ❑gums tender | ❑clench or grind teeth | ❑previous gum treatment |
| ❑food catches | ❑growths, sores in mouth | ❑jaw joint pain | ❑previous bite treatment |
| ❑loose teeth | ❑cold sores, fever blisters | ❑clicking or popping of joint | ❑wear night guard |
| ❑floss breaks easily or hurts | | | |

Would you like whiter teeth?_______ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?____________________________________________
Please rate 1-10 how anxious you are about dental treatment (1= totally relaxed)________________________
Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?)________________________
Why did you leave your previous dentist?________________________________________
Did your parents have difficulties with their teeth or dental treatments?________________________

## Medical History

Physician's Name______________________________ Phone Number______________________________
Have you been hospitalized for any reason? Please describe
____________________________________________
____________________________________________
Are you taking any medications or drugs including over the counter and nutritional supplements? Please list
____________________________________________
Are you allergic to anything including Penicillin or other antibiotics, Aspirin, codeine, Tylenol or other pain-killers, latex or metal?
____________________________________________
Do you smoke? How much per day? How many years?______________________________
Pregnant?_________________ due date____________________ Are you nursing?______________________
Are you seeing a physician right now or planning to see one for any reason? Please explain
____________________________________________

***Please check all that apply to your history:***

| | | | |
|---|---|---|---|
| ❑previous injury to head or neck | ❑Diabetes | ❑digestive problems, ulcer | ❑shortness of breath |
| ❑heart problem | ❑HIV or AIDS | ❑thyroid disease | ❑snoring/sleep apnea |
| ❑heart attack | ❑kidney problem | ❑glaucoma | ❑easily winded |
| ❑angina/chest pain | ❑liver problem/jaundice | ❑bleed or bruise easily | ❑no energy |
| ❑heart murmur | ❑cirrhosis/hepatitis | ❑stroke | ❑fainting or dizzy |
| ❑Scarlet/rheumatic fever | ❑cancer | ❑epilepsy or seizures | ❑unexplained weight loss |
| ❑mitral valve prolapse | ❑radiation/chemotherapy | ❑Parkinson's | ❑chewing tobacco |
| ❑irregular heartbeat | ❑respiratory problems | ❑Alzheimer's | ❑drug or alcohol addiction |
| ❑high or low blood pressure | ❑bloody/persistent cough | ❑back problem | ❑2 or more social drinks/day |
| ❑pacemaker | ❑asthma/emphysema | ❑hives/rash | ❑anxiety or nervous disorder |
| ❑artificial joint | ❑anemia | ❑herpes | ❑insomnia |
| ❑organ recipient | ❑blood clotting disease | ❑dry eyes | ❑wear contact lenses |

Any other illnesses not checked above: ____________________________________________
Please indicate if you would prefer to speak privately to the dentist about a medical issue: ❑YES ❑NO
Please rate the following indicators or your **daily stress level 1-10 (1=low, 10= high)**
**___Overworked, too busy, pressured ____feel frustrated ____Get upset or "snap" easily ____Depression ____Anxiety**

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.
Patient Signature (parent/guardian)________________________________ Date____________________
Dentist's Signature________________________________ Date____________________

## Petrolia Dental - New Patient-Financial Agreement

**Date: _______________ Name of Patient (Family Name)______________**

**Total Estimated Cost: New Patient Complete Oral Evaluation (NP COE) = ~$ 300 (not including cleaning) *prices effective January 2009**

*Includes:*

- **Complete Oral Examination and Diagnosis**
- **X-rays (Bite-Wings and Panoramic X-ray)**
- **Diagnostic Photographs**
- **Periodontal Assessment, Oral Cancer Screening, bite assessment**

***It is necessary to do a COE as we have several hygiene programs and also have no dental history on yourself, as we have never seen you before.***

**(* Note a "cleaning" and other services are in addition to this. *)**

## Payment

**We are a non-assignment office. This means that we submit to your insurance company for your direct reimbursement.**
**Payments can be made with the use of cash, debit card, visa and master card**

I, _______________understand that I am financially responsible to my dentist for all fees and charges applied to the services I have received. (Signature) ___________________

# Petrolia Dental – Alberta Privacy Legislation

**14034-23 Ave Edmonton, AB T6R 3L6 (780) 435-3784**

On January 1st, 2004 the **Alberta Personal Information Protection Act (PIPA)** and the **Federal Personal Information Protection and Electronics Act (PIPEDA)** came into place. In accordance with this legislation, all patients must sign a standard written consent form for our office to gather and use personal information.

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").*** 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 practice.

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").*** Patient's Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. Patient's Medical 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.
- 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, dental specialists, and other health care professionals where those professionals have asked us, with the consent of the patient, to provide a second opinion.

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 of Patient/Guardian** |