Welcome to our dental family

Patient's Name | Date of Birth

E-mail

Address | Town/Province | Postal Code

Cell Number | Home number | Work Number (only if we can contact you there)

YOUR PREFERRED METHOD OF CONTACT DURING THE HOURS OF 8AM TO 5PM (please choose one):

☐ Text ☐ Email ☐ Call my cell phone ☐ Call work ☐ Call home

WHO CAN WE THANK FOR REFERRING YOU? (Friend or Family Member) ______________________________

HOW DID YOU HEAR ABOUT OUR OFFICE?

(Please Check **ALL** that apply)

☐ Received Mail ☐ Email ☐ Yellow Pages ☐ Community Events ☐ Newspaper

☐ I saw the sign ☐ Radio ☐ Movie Theatre ☐ Google ☐ Facebook ☐ Instagram

CONSENT FOR PROCEDURES: This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated. I assume responsibility for fees associated with those procedures. I consent to the use of my mobile phone number email address for Slave Lake Dental to text and email me appointment reminders, upcoming events, marketing, sales etc... I also consent to the use of any photographs taken of me, or my mouth to be used in promotional and/or educational materials.

Patient Signature | Date:

MEDICAL HISTORY AS OF (Date): ______________________________

The following information is required to thoroughly diagnose any condition and to give the highest possible standard of professional care. All information will be kept strictly confidential.

1. Name of medical doctor______________________________________
2. Have you had a medical exam within the last year? YES NO
3. Are you under a doctor's ongoing care at the present time? YES NO
   (a) If so, for what problem? ______________________________________
4. Have you been hospitalized or had a serious illness within the last 5 year? YES NO
   (a) If so, for what problem? ______________________________________
5. Are you taking any drug or medicine? Y / N Oral Contraceptive? YES NO
   (a) If so, what? ______________________________________
6. Are you allergic to or have you reacted adversely to any of the following drugs or medicines? Please CIRCLE

Aspirin
Codeine
Penicillin
Valium
Percodan
Erythromycin
Tetracycline
Sulfa
Nitrous Oxide
Darvon
Local Anaesthetic
Other: ______________________________________

7. Have you ever had any of the following diseases or problems? Please CIRCLE

Heart Attack
Heart Disease
Congenital Heart Lesions
Rheumatic Fever
Angina
Pains in chest
Shortness of breath
Swollen ankles
Diabetes
Stroke
Blood Pressure
Anaemia
Allergy
Asthma
Arthritis
Epilepsy
Cancer
Lung (tuberculosis, emphysema, other)
Liver (hepatitis, jaundice, other)
Kidney Disease
Gastrointestinal Problems (e.g. ulcers)
Endocrine Disorder (e.g. thyroid)
HIV/AIDS
Cerebral Palsy
Multiple Sclerosis

8. Have you ever had abnormal bleeding associated with previous extractions? YES NO
9. Do you bruise easily? YES NO
10. Have you been in a vehicle or sporting accident and suffered head, neck or facial trauma? YES NO
11. Do you snore? YES NO Have you been tested for Sleep Apnea? YES NO
    Do you have a CPAP? YES NO If yes, do you regularly use it? YES NO
12. LADIES- Are you or do you have reason to believe you are pregnant? YES NO
13. Do you have any disease or problem not listed above that you feel we should know about?

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE.

____

Patient Signature Date:

OUR FINANCIAL OPTIONS

In order to provide you with maximum flexibility in your payment options and ensure our commitment of “no financial surprises” for our patients please review the following options for payments and **choose the best option for you**.

☐ OPTION 1 - Express Checkout

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- **We will take payment from your insurance and you only pay what is left.**
- **You will authorize Slave Lake Dental to keep a credit card on file** and to issue a charge to your account for any balance of $200 or less that is still owed once your insurance portion is finalized. Your card will only be charged for treatment already completed.
- It may take up to 16 weeks to receive payment from your benefits and charge your credit card. Receipts will be mailed to you for your records.
- If on the day you receive treatment your insurance company is able to provide us with a finalized amount they will cover you will have the option to pay by cash or debit if you would prefer.

☐ OPTION 2 - Fee for Service

- You will **pay in full at each appointment** for treatment and if you have dental benefits they will send payment directly to you.
- You will **never have to worry about having outstanding account balances**
- We will always send insurance claims on your behalf and help you with any submissions.

Patient Signature Date:

CREDIT CARD AUTHORIZATION FORM

This form will be securely destroyed upon completion

PATIENT AGREEMENT Please complete the information below. It will be kept confidential and secure and will only be used under the agreed terms.

I agree to the FINANCIAL RESPONSIBILITY for the following: Account balance

I, ____, authorize Slave Lake Dental to charge the credit card listed below for any balance owing upon their receipt of my insurance funds up to $200 per account for the account balance belonging to the following patients:

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________

Payment to be made by: Visa MasterCard

Credit Card # ____

Expiry Date: ____________________________

CCV: ____________________________

Name on the card: ____________________________

Signature: ____________________________

PRIVACY, DISCLOSURE, & CONSENT

Information for our new Patients

At Slave Lake Dental, all professional services are performed by licensed members of the ("Dental Professionals"), and all institutional services are performed independently by Slave Lake Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Slave Lake Dental and Slave Lake Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Slave Lake Health Services.

Privacy Act and Consent to Treatment

By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Slave Lake Dental; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Slave Lake Dental to provide the services you are requesting.

Acknowledgement regarding Information Provided

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical – dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among Slave Lake Dental, Slave Lake Health Services, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Slave Lake Dental and in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that the Slave Lake Dental and Slave Lake Health Services are relying upon the information which I have provided being accurate and complete.

______________________	______________________	______________________
Print Name ☐ Patient ☐ Guardian	**Signature**	**Date**

______________________	______________________
Slave Lake Dental Team Member	Date

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