slave lake DENTAL

Exceptional People Putting Patients First

Slave Lake Dental KID Crew est. 2016 kids inspired dentistry

Child #1 Name Date of Birth

Child #2 Name Date of Birth

Child #3 Name Date of Birth

Child #4 Name Date of Birth

Child #5 Name Date of Birth

Guardian's Name **Date of Birth**

Guardian's E-mail (we use this primarily to confirm your appointments)

Guardian's Address **Town/Province** **Postal Code**

Guardian's Cell Number **Home number** **Work Number** (only if we can call you)

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 on the above named children/dependants that are agreed to be necessary or advisable, including the use of local anaesthetic as indicated. I assume responsibility for fees associated for all of the above listed children/dependants and their associated procedures. I consent to the use of my mobile phone number and email address for Slave Lake Dental to text and email me appointment reminders, upcoming events, marketing pieces, sales, etc. I also consent to the use of any photographs taken of my children/dependants mouth and teeth to be used in promotional and/or educational materials.

Signature of Legal Guardian 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 - Fee for Service

This option is for patients with no dental insurance **AND** for our patients with insurance who would like the following conveniences:

- You will gain control of your benefits by **paying in full at each appointment** for treatment and being reimbursed directly by your insurance company.
- This will enable you to keep personal records of all dental transactions, all insurance reimbursements, track maximum allowable benefits and you will be more aware of what your plan does and does not cover.
- You will **never have to worry about having outstanding account balances** with us and you will not have to come in to collect monies that we may owe to you.
- When insurance companies are reimbursing patients, payment usually takes one to two weeks to be received, especially if your plan accepts electronic dental claims.
- We will always send insurance claims on your behalf and help you with any submissions.

☐ OPTION 2 - Express Checkout

Our Express Checkout Program allows us to continue to offer you the convenience of using your insurance plan as a form of direct payment. **We will take payment from your insurance and you only pay what is left.**

- Allows you to "SET IT AND FORGET IT" – paying for your care is a breeze as everything to do with payments has been pre-arranged.
- **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.
- For our office to collect from insurance may take anywhere from 1-16 weeks – please keep this in mind when watching your credit card statements. Receipts will be mailed to you for your records.
- You will only be notified in advance of any charge in excess of $200.00.
- 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.

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: _____

CHILD'S/DEPENDANT'S NAME: _____

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 your child's/dependants medical doctor_____
2. Has your child/dependant had a medical exam within the last year? YES NO
3. Is your child/dependant under a doctor's ongoing care at the present time? YES NO
   - If so, for what problem? _____
4. Has your child/dependant been hospitalized or had a serious illness within the last 5 years? YES NO
   - If so, for what problem? _____
5. Is your child/dependant taking <u>any</u> drug or medicine including oral contraceptives? YES NO
   - If so, what? _____
6. Is your child/dependant allergic to or have they reacted adversely to any of the following drugs or medicines? Please CIRCLE:

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

   Other: _____

7. Has your child/dependant ever had any of the following diseases or problems? Please CIRCLE:

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

8. Has your child/dependant ever had abnormal bleeding associated with an extraction? YES NO
9. Does your child/dependant bruise easily? YES NO
10. Has your child/dependant ever been in a vehicle/sporting accident and suffered head, neck or facial trauma? YES NO
11. Does your child/dependent have any disease or problem not mentioned above that you feel we should know about? YES NO If so, what? _____

I acknowledge that the information above is true and to the best of my knowledge

Guardian Signature Date:

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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