Emerald Hills
DENTAL CENTRE
#170 8005 EMERALD DRIVE.
SHERWOOD PARK, AB T8H 0P1

Welcome to our Dental Practice! We are looking forward to meeting you and your family and caring for your Dental health. The following information is required by the Dentist to assist in proper diagnosis and treatment. Please feel free to ask our Reception for help in completing this form. PLEASE PRINT. ***(ALL INFORMATION IS CONFIDENTIAL.)***

In order to treat you with the Respect and Courtesy that you deserve, we would be extremely grateful if you could tell us a little about yourself.

LAST NAME_____.	**S. I. N.** _____
FIRST NAME_____.	**A.H.C.** _____
MIDDLE_____.	BIRTHDAY Mth: _____ Day: _____ Yr:_____
PREFERRED NAME _____	How did you hear about our clinic? _____
MALE _____ FEMALE _____	----------
MAILING ADDRESS _____.	Night Time (home) # ( ) _____
_____	Day Time (work) # ( ) _____
CITY _____ PROVINCE_____	CELL # ( ) _____
.	EMAIL ADDRESS _____
POSTAL CODE_____	

Other members of your immediate family that visit our office_____ _____

FAMILY PHYSICIAN _____ TEL : _____

MEDICAL ALERTS _____

IN CASE OF AN EMERGENCY, WHO CAN WE CALL THAT IS NOT LISTED ABOVE

INSURANCE INFORMATION

POLICY HOLDER NAME _____ POLICY HOLDER NAME _____

POLICY HOLDR EMPLOYERS NAME _____ POLICY HOLDR EMPLOYERS NAME _____

POLICY HOLDER DATE OF BIRTH _____ POLICY HOLDER DATE OF BIRTH _____

INS COMPANY NAME [**1**] _____ INS COMPANY NAME [**2**] _____

GROUP / POLICY # _____. GROUP / POLICY # _____

ID/ CERT # _____. ID/ CERT # _____

FOR PATIENTS WITH PLAN BENEFITS (INSURANCE) SOME PLAN BENEFITS ALLOW FOR SPOUSAL SIGNATURES.

As majority of the Insurance companies are now being billed electronically you (the insured/spouse) allow electronic billing and assign benefits payable from claims to the named dentist and authorize payment to him/her. You (the Insured/spouse) understand that you are financially responsible for the procedures done and the fees charged as they may not be covered by or may exceed your plan benefits.

Signature of Insured/ Spouse _____ Date _____

We are committed to protecting the privacy of our patient's 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 address, work address, home telephone numbers, work telephone numbers and e-mail addresses (collectively related to as contact information). Contact information is 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 file claims through CDA net (Electronic filing)
- 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 examinations or treatment
- To send patients information material from our dental practice

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim 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.

Personal information may be collected in order to make arrangements for payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition and past dental treatments (Collectively referred to as "Medical Information"). Patients medical information is collected to be used for the purpose of diagnosing dental conditions and providing dental treatment.

Patient 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 transferred by us to the other dentist or dental specialist for treatment.
- To other dentists or 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 to us by other health care professionals for either a second opinion or treatment.

If we are 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 staff as part of their regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal information as set above.

_____	_____	_____
Date	Print Name	Signature

Emerald Hills
DENTAL CENTRE
#170 8005 Emerald Drive.
Sherwood Park, AB T8H 0P1

Patient Name: _____

Family Doctor: _____

Date: _____

Yes	No	Question	
[ ]	[ ]	1. Have you been under the care of a physician recently ?	Please Specify
[ ]	[ ]	2. Have you ever had a serious illness	Please Specify
[ ]	[ ]	3. Have you ever had any type of Allergy, Hay Fever or Asthma ?	Please Specify
[ ]	[ ]	4. Have you ever had a reaction to a drug ?	Please Specify
[ ]	[ ]	5. Are you taking any medication at present ?	Please Specify
[ ]	[ ]	6. Have you ever fainted?	Please Specify
[ ]	[ ]	7. Do you bleed easily or do cuts in your skin stay open a long time ?	Please Specify
[ ]	[ ]	8. Have you had pains in your chest ?	Please Specify
[ ]	[ ]	9. Have you ever had Heart Disease, High Blood Pressure, Diabetes, Kidney, Hepatitis (A, B, C etc.), or Epilepsy?	Please Specify
[ ]	[ ]	10. Have you ever had any injury, surgery or x-ray therapy to the face or jaws ?	Please Specify
[ ]	[ ]	11. Are you presently in good health ?	Please Specify
[ ]	[ ]	12. Do you have any contagious diseases …. Aids, Hep, TB, Yeast Infections, Other?	Please Specify
[ ]	[ ]	13. Women – Are you Pregnant? Are you taking any Oral Contraceptives?	Please Specify
[ ]	[ ]	14. Are you currently a smoker or have you been a smoker in the past?	Please Specify