PATIENT INFORMATION

Welcome to our office! We appreciate the confidence you place with us to provide your dental services.
Please complete and save forms and email to info@toothville.ca

Patient Name: _____ Date of Birth: DD/MM/YYYY Sex: _____ Age: _____

Home Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Mobile Phone: _____ Work: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Name of previous dentist: _____ Date of last visit to a dentist: _____

WHOM MAY WE THANK FOR YOUR REFERRAL: _____

YOUR DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Company Name: _____

Subscribers/Policy Holders Name: _____ DOB: DD/MM/YYYY

Group#_____ ID or CERT#_____ Coverage: Basic %____ Major %____ Maximum/Yr ____

What restrictions do you have on your dental plan?
(ie. How often is polishing covered? Is fluoride covered? How many units of scaling are covered?)

SECONDARY DENTAL INSURANCE

Company Name: _____

Subscribers/Policy Holders Name: _____ DOB: DD/MM/YYYY

Group#_____ ID or CERT#_____ Coverage: Basic %____ Major %____ Maximum/Yr ____

What restrictions do you have on your dental plan?
(ie. How often is polishing covered? Is fluoride covered? How many units of scaling are covered?)

Patient Name: _____ Nickname: _____ Age: _____

Name of Physician (Medical Doctor)/and their specialty _____

Most recent physical examination: _____ Purpose: _____

What is your estimate of your general health? ○ Excellent ○ Good ○ Fair ○ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		Yes	No
1.	Hospitalization for illnessor injury	○	○
2.	An allergic reaction to	○	○
	☐ aspirin,ibuprofen,acetaminophen, codeine		
	☐ penicillin		
	☐ erythromycin		
	☐ tetracycline		
	☐ sulfa		
	☐ local anesthetic		
	☐ fluoride		
	☐ latex		
	☐ metals (nickel, gold, silver, _____)		
	☐ other		
3.	Heartproblems,or cardiac stent within the last six months	○	○
4.	History of infective endocarditis	○	○
5.	Artificial heart valve, repaired heart defect(pfo)	○	○
6.	Pacemaker or implantable defibrillator	○	○
7.	Artificial prosthesis (heart valve or joints)	○	○
8.	Rheumatic or scarlet fever	○	○
9.	○ High or ○ Low blood pressure (Please check one)	○	○
10.	Astroke (taking blood thinners)	○	○
11.	Anemiaor other blood disorder	○	○
12.	Prolonged bleeding due to a slight cut(inr>3.5)	○	○
13.	Emphysema,shortness of breath, sarcoidosis	○	○
14.	Tuberculosis, measles, chickenpoxs	○	○
15.	Asthma	○	○
16.	Breathing or sleep problems (i.e.Sleepapnea,snoring,sinus)	○	○
17.	Kidney disease	○	○
18.	Liver disease	○	○
19.	Jaundice	○	○
20.	Thyroid, parathyroid disease, or calcium deficiency	○	○
21.	Hormone deficiency	○	○
22.	High cholesterol or taking statin drugs	○	○
23.	Diabetes (hba1c=)	○	○
24.	Stomach or duodenal ulcer	○	○
25.	Digestive disorders(i.e. celiac disease, gastric reflux)	○	○
26.	Osteoporosis/osteopenia (i.E. Taking bisphosphonates)	○	○
27.	Arthritis, rheumatoid arthritis, lupus	○	○
28.	Glaucoma	○	○
29.	Contact lenses	○	○
30.	Head or neck injuries - specify:	○	○
31.	Epilepsy, convulsions (seizures)	○	○
32.	Neurologic disorders (add/adhd, prion disease)	○	○
33.	Viral infections and cold sores	○	○
34.	Any lumps or swelling in the mouth	○	○
35.	Hives, skin rash, hay fever	○	○
36.	STI /STD - Specify.	○	○
37.	Hepatitis - type	○	○
38.	HIV/AIDS	○	○
39.	Tumor, abnormal growth	○	○
40.	Radiation therapy	○	○
41.	Chemotherapy, immunosuppressive	○	○
42.	Emotional problems	○	○
43.	Psychiatric treatment	○	○
44.	Antidepressant medication	○	○
45.	Alcohol/street drug use? Specify:	○	○

ARE YOU:

46.	Presently being treated for any other illness	○	○
47.	Aware of a change in your health in the last 24 hours (i.e. Fever, chills, new cough, or diarrhea)	○	○
48.	Taking medication for weight management (i.e. Fen-phen)	○	○
49.	Taking dietary supplements	○	○
50.	Often exhausted or fatigued	○	○
51.	Experiencing frequent headaches	○	○
52.	A smoker, smoked previously or use smokeless tobacco	○	○
53.	Considered a touchy person	○	○
54.	Often unhappy or depressed	○	○
55.	FEMALE -taking birth control pills	○	○
56.	FEMALE - pregnant	○	○
57.	MALE - prostate disorders	○	○

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient/Guardian Signature _____ Date _____

Name _____ Nickname _____ Age _____ Referred by _____

How would you rate the condition of your mouth? ○ Excellent ○ Good ○ Fair ○ Poor

Previous Dentist _____ How long have you been a patient? _____ Months _____ Years

Date of most recent dental exam _____ Date of most recent x-rays _____

Date of most recent treatment (other than a cleaning) _____

I routinely see my dentist every: ○ 3 mo. ○ 4 mo. ○ 6 mo. ○ 12 mo. ○ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) 1 _____
2. Have you had an unfavorable dental experience? ..... ○ ○
3. Have you ever had complications from past dental treatment? ..... ○ ○
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ..... ○ ○
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ..... ○ ○
6. Have you had any teeth removed? ..... ○ ○

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ..... ○ ○
8. Have you ever been treated for gum disease or been told you haw lost bone around your teeth? ..... ○ ○
9. Have you ever noticed an unpleasant taste or odor in your mouth? ..... ○ ○
10. Is there anyone with a history of periodontal disease in your family? ..... ○ ○
11. Have you ever experienced gum recession? ..... ○ ○
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? .. ○ ○
13. Have you experienced a burning sensation in your mouth? ..... ○ ○

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ..... ○ ○
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ..... ○ ○
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ..... ○ ○
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ..... ○ ○
18. Do you have grooves or notches on your teeth near the gum line? ..... ○ ○
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ..... ○ ○
20. Do you frequently get food caught between any teeth? ..... ○ ○

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ..... ○ ○
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? ..... ○ ○
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? .... ○ ○
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ..... ○ ○
25. Are your teeth crowding or developing spaces? ..... ○ ○
26. Do you have more than one bite and squeeze to make your teeth fit together? ..... ○ ○
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ..... ○ ○
28. Do you clench your teeth in the daytime or make them sore? ..... ○ ○
29. Do you have any problems with sleep or wake up with an awareness of your teeth? ..... ○ ○
30. Do you wear or haw you ever worn a bite appliance? ..... ○ ○

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change? ..... ○ ○
32. Have you ever whitened (bleached) your teeth? ..... ○ ○
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? ..... ○ ○
34. Have you been disappointed with the appearance of previous dental work? ..... ○ ○

Patient/Guardian Signature _____

Tooth Ville Family Dentistry Privacy Policy Consent Form

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, home and/or work telephone numbers, and e-mail 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 and/or legal guardians or persons financially responsible for patient accounts, for dental services, to process credit card payments, or to collect unpaid accounts.
- In To process claims for payment or reimbursement from third-party benefit providers, insurance companies and government agencies.
- 1, To send reminders to patients concerning the need for further dental examination or treatment. In 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 from whoever has been written as financially responsible for the account.

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"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed:

- To all third-party benefit providers, insurance companies and government agencies where a claim is being submitted for reimbursement or payment of all or part of the cost of dental treatment.
- To other dentists and dental specialists, where further information and/or discussion is required.
- To other dentists and dental specialists if the patient has been referred by us to the other dentist of dental specialist for treatment.
- To other health care professionals such as physicians if the patient has been referred by us to the other health care professional for either a second opinion or treatment.
- Where we are seeking and/or providing information to the following: laboratories, radiology centres, hospitals, etc.
- To include the following when necessary, such as: videos, pictures, slides, etc., for educational purposes.

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 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 interests.

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

Patient/Guardian Signature _____ **Date** _____

ToothVille Family Dentistry Office Policies

Appointment Reminders

Please understand that it is your responsibility to keep track of your appointments. We will do everything we can to ensure you receive reminders, and have adequate time to make arrangements or change appointments.

Cancellations

We require a minimum of 24 hours notice to modify scheduled appointments, and 72 hours notice for Monday appointments. This is valuable time that has been reserved for you with the Dentist/Hygienist. In the event that insufficient notice is given, a charge of $50 may be applied to your account.

Direct Billing Insurance & Payment Arrangements

The Canadian Personal Privacy Act prohibits us from accessing information from most insurance carriers. As every policy is unique, it is your responsibility to know the details of your plan (annual maximums, frequencies, other limitations). We do direct bill to insurance as a courtesy, and will submit pre-determinations (estimates) for major treatment, however, it is important that you understand the details of your policy to utilize your benefits to their maximum and avoid any discrepancies.

I have read the above information and understand the office policies.

Signature: _____ Date: _____

Below are 2 payment options available to you. Please CHECK the option you would like to participate in.

Option 1 ◯ Payment is due in full on the day the treatment is completed. We accept cash, Debit, MasterCard & Visa. Your payment will be processed and insurance documents will be generated and submitted to your insurance carrier. Your Insurance carrier will pay you directly.

Option 2 ◯ We will direct bill your insurance carrier. If we receive an explanation of benefits from your insurance carrier following your visit, the outstanding balance will be collected before you leave. You will be required to leave a credit card on file. If there is a balance on your account following insurance payments, it will be charged to the card on file and a receipt for payment will be emailed to you. **A credit card is not required for Alberta Works.**

Direct Billing is a courtesy we offer to our patients and in order to 'Direct Bill' your insurance provider, we require a credit card on file for any outstanding amounts owing after your insurance provider has paid their portion. Outstanding accounts over 60 days will be charged 2% interest monthly.

I hereby agree to the Financial Policy of ToothVille Family Dentistry as outlined above, and authorize ToothVille Family Dentistry to apply any outstanding balance on my account, not covered by my insurance provider, to the credit card listed below:

Payment options are as follows:

☐ **VISA** ☐ **MASTERCARD**

Card#: _____ **Exp. Date:** _____ **CVV:** _____

Name on card: _____

Authorized Signature: _____