

New Patient Form

Millrise Dental Clinic - 15 Millrise Blvd. S.W., Calgary, AB, T2Y 1X7

Patient Information			
Patient Name	Preferred Name	Sex	Birthdate
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address			
<input type="text"/>			
City	Province	Postal Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Home Phone	Cell Phone	Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Whom may we thank for referring you to us?		If you have insurance: Name of the Policy Holder:	
<input type="text"/>		<input type="text"/>	

Please read the following:

By providing an email address, I agree to receive emails that contain information such as appointment reminders, referrals, account details, and information relating to dental treatment plans and procedures.

I consent to the dental procedures agreed to be necessary or advisable for myself or child, including the use of local anaesthetic or other drugs as indicated, and I will assume responsibility for the fees associated with those procedures.

I authorize electronic submissions to my dental benefits.

Your signature gives us permission to use the credit card you provide us in the office for balances on the account.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AS WELL AS THE OFFICE POLICY PROVIDED BELOW

Office Policies for insurance, accounts & appointments

Insurance

As a courtesy to our patients, **WE DO ACCEPT PAYMENT FROM YOUR INSURANCE COMPANY**, if allowed by your employer.

We will work on a claim for 90 days and if we have not been paid, then the claim in question must be paid by the patient and they must then work it out with their insurance company.

Insurance information needed

The Privacy Act prevents us from getting certain information from your insurance company.

You must supply us with additional information we need if you wish to have us bill your insurance directly.

1. Recall Frequency and units of scaling allowed
2. Annual Maximums and percentages for Basic and Major treatment
3. Benefit year if different than a calendar year

If you have a policy book please bring to an appointment and we can extract the information that we need.

Please be reminded that your insurance is a contract between your insurance company and yourself NOT the dental office. We will do our best to help you keep track of your maximums and frequencies but it is ultimately your responsibility to know the plan limits. We are happy to help you with any questions.

Preauthorizations

Most insurance companies do not send the information for predeterminations to the dental office. We need this information to allow us to calculate what or if there is a portion for the patient to pay, which is due at the time of your appointment. Some plans do not include the lab costs on their information to the patient so the total cost to them is not correct. Most preauthorizations done are for major restorative work e.g. Crowns, bridges & implants and the benefits vary greatly between insurances. This information can be faxed, e-mailed, or brought into the office.

Account

Any amount owing is due the day of your appointment. We ask that a current credit card (Visa or Mastercard), be placed on file for any balances that occur after your insurance has paid their portion, even with dual coverage there can be a balance. Insurance plans will pay different percentages for procedures and pay on **what is allowed on your plan**, not what our charges are. If you do not have a credit card or do not wish to give one, then we ask for a 25% deposit of any unknown amounts. Any unused money paid to us will be reimbursed to you.

Appointments

Should you need to change your dental appointment, please remember that we do require 2 business days notice. This allows us time to fill the vacant spot. **As a courtesy**, we will remind you of your appointment 2-3 days prior by e-mail, phone or text message, but it is still **your responsibility** to record your appointments when you make them and keep them. Recall appointments can be made up to a year in advance and we will remind you two weeks prior to give you lots of time to rebook if necessary, you'll also receive a 2 day reminder in addition.

Medical History

1) Do you have any prescription allergies? Yes No

If yes, please check all that apply:

- | | | |
|----------------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Acetaminophin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Tetracycline |

Other prescriptions allergies:

2) Do you have any other allergies? Yes No

If yes, please list:

3) Do you have any health conditions? Yes No

If yes, please check all that apply:

- | | | |
|------------------------------------------------|---------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Drug/Alcohol |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Epileptic | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Hormone Deficiency | <input type="checkbox"/> Hypersensitive | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> Smoker | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Thyroid Disease | |

Other health conditions not listed:

4) Do you have asthma or any other respiratory diseases? Yes No

Respiratory disease and type of medication taken:

5) Do you have any special needs? Yes No

If yes, please check all that apply:

- | | | |
|-----------------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Do not recline chair | <input type="checkbox"/> Gag reflex | <input type="checkbox"/> Neck Roll |
| <input type="checkbox"/> Nervous in chair | <input type="checkbox"/> No flouride | <input type="checkbox"/> No Xrays |

Tendency to faint

Any other needs not listed:

[Empty text box for other needs]

6) Do you have any heart conditions?

If yes, please check all that apply:

Yes No

Cardiac Stent

High Blood Pressure

Heart Transplant

Heart Valve/Repair

Infective Endocarditis

Low Blood Pressure

Pacemaker

Rheumatic Fever

Other conditions not listed:

[Empty text box for other heart conditions]

7) Have you had any joints replaced?

Type of joint replacement and date:

Yes No

[Empty text box for joint replacement details]

8) Have you ever had to take antibiotics prior to dental work?

Reason for taking antibiotic:

Yes No

[Empty text box for antibiotic reason]

9) Are you taking any medications?

If yes, please list:

Yes No

[Empty text box for medications]

10) When was your last dental visit?

[Empty text box for last dental visit]

11) Which dental office?

[Empty text box for dental office]

12) When was your last physical?

[Empty text box for last physical]

13) Personal Physician

[Empty text box for personal physician]

14) Are you pregnant?

Yes No

15) Do you have any infectious disease?

If yes, please check all that apply:

Yes No

Hepatitis A

Hepatitis B

Hepatitis C

Herpes/Cold sores

HIV Positive/AIDS

Tuberculosis

Venereal Disease

16) Have you had any other surgeries or been hospitalized?

Please list surgeries or hospitalizations and when:

Yes No

[Empty text box for surgeries/hospitalizations]

17) Do you smoke?

If yes, how much?

Yes No

[Empty text box for smoking details]

18) Do you use chewing Tabacco?

Yes No

19) Do you have a persistent cough?

Yes No

20) Do you have a reaction to Epinephrine?

Yes No

21) Do you have a compromised immune system?

Yes No

22) Do you have a latex allergy?

Yes No

23) Do you have diabetes?

Yes No

24) Are you handicapped/in a wheelchair?

Yes No

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AS WELL AS THE OFFICE POLICY

First & Last Name

Email Address

[Empty text box for name]

[Empty text box for email address]

Draw your signature