New Patient Form

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

Patient Information

Patient Name | Preferred Name | Sex | Birthdate

Address

City | Province | Postal Code

Home Phone | Cell Phone | Email

Whom may we thank for referring you to us? | If you have insurance: Name of the Policy Holder:

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 responsability 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 responsability 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 responsability** 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:

- ☐ Acetaminophin
- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Ibuprofen
- ☐ Morphine
- ☐ Penicillin
- ☐ Sulfa
- ☐ 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:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Birth Control
- ☐ Bleeding Disorder
- ☐ Contact Lenses
- ☐ Depression
- ☐ Digestive Disorder
- ☐ Drug/Alcohol
- ☐ Emotional Problems
- ☐ Epileptic
- ☐ Glaucoma
- ☐ Head Trauma
- ☐ Hearing Impaired
- ☐ High Cholesterol
- ☐ Hormone Deficiency
- ☐ Hypersensitive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Neurological Disorder
- ☐ Osteoporosis
- ☐ Pregnant
- ☐ Prostate
- ☐ Psychiatric Treatment
- ☐ Smoker
- ☐ Snoring
- ☐ Stomach Ulcer
- ☐ 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:

- ☐ Do not recline chair
- ☐ Gag reflex
- ☐ Neck Roll
- ☐ Nervous in chair
- ☐ No flouride
- ☐ No Xrays

☐ Tendency to faint

Any other needs not listed:

6) Do you have any heart conditions? ○ Yes ○ No

If yes, please check all that apply:

☐ Cardiac Stent
☐ Heart Valve/Repair
☐ Pacemaker
☐ High Blood Pressure
☐ Infective Endocarditis
☐ Rheumatic Fever
☐ Heart Transplant
☐ Low Blood Pressure

Other conditions not listed:

7) Have you had any joints replaced? ○ Yes ○ No

Type of joint replacement and date:

8) Have you ever had to take antibiotics prior to dental work? ○ Yes ○ No

Reason for taking antibiotic:

9) Are you taking any medications? ○ Yes ○ No

If yes, please list:

10) When was your last dental visit?

11) Which dental office?

12) When was your last physical?

13) Personal Physician

14) Are you pregnant? ○ Yes ○ No

15) Do you have any infectious disease? ○ Yes ○ No

If yes, please check all that apply:

☐ Hepatitis A
☐ Herpes/Cold sores
☐ Venereal Disease
☐ Hepatitis B
☐ HIV Positive/AIDS
☐ Hepatitis C
☐ Tuberculosis

16) Have you had any other surgeries or been hospitalized? ○ Yes ○ No

Please list surgeries or hospitalizations and when:

17) Do you smoke? ○ Yes ○ No

If yes, how much?

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

Draw your signature