STONY PLAIN
DENTAL CENTRE

3919 49th Avenue Suite 109
Stony Plain, Alberta T7Z 1V5
Phone: 780-963-4626
Fax: 780-963-0195
www.stonyplaindental.com
admin@stonyplaindental.com

NEW PATIENT CONFIDENTIAL INFORMATION AND HEALTH HISTORY

TODAYS DATE

_____

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____
Sex: ☐ M ☐ F ☐ Other Date of Birth: _____ Age: ____ Height: ____ Weight: ____
Marital Status: _____ Name of Spouse: _____
Mailing/Home Address: _____ Postal Code: _____
City/Town: _____ Email Address: _____
Home Phone: _____ Cell Phone: _____ Preferred: ☐ Home ☐ Cell
Employer/School: _____-_____
Personal Physician: _____ Phone: _____
Emergency Contact: _____ Relationship: _____
Phone: _____

REFERRAL INFORMATION

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

☐ Community BBQ ☐ Facebook ☐ Google ☐ Instagram ☐ Tradeshow
☐ Farmer's Day Parade ☐ Movie Event ☐ Website ☐ Location ☐ Clinic/Patient Referral
*Please fillout the line below

Name of person or office referring you to our practice: _____
☐ Other, please explain: _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY
Employer: _____
Business Address: _____
Phone: _____
Insurance Co.: _____
Policyholder Name: _____
Policyholder DOB: _____
Policy/Group No.: _____
ID Number: _____

SECONDARY DENTAL INSURANCE COMPANY
Employer: _____
Business Address: _____
Phone: _____
Insurance Co.: _____
Policyholder Name: _____
Policyholder DOB: _____
Policy/Group No.: _____
ID Number: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship: _____
Phone: _____ Email: _____

NEW PATIENT CONFIDENTIAL INFORMATION AND HEALTH HISTORY

DENTAL INFORMATION

Reason for today's visit: ☐ Emergency ☐ Exam ☐ Other:_____

Previous Dentist: _____ Phone: _____

Last Dental Exam/X-Rays: _____ Last Dental Hygiene Visit: _____

How many times a day do you brush: _____ How many times a day do you floss: _____

COSMETIC INFORMATION

Our office offers Neuromodulators (Botox, Xeomin) to alleviate grinding and/or improve face esthetics (wrinkling), would you be interested in more information? ☐ Yes ☐ No

We also offer whitening and Invisalign (clear braces). Would you like more information? ☐ Yes ☐ No

How would you rate your smile?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Is there anything you would like to change about your smile?

_____

MEDICAL HISTORY AND INFORMATION

Have you ever had or have any of the following? Please check that apply so that we may treat you safely:

☐ Acid Reflux	☐ AIDS/HIV	☐ Alcoholism
☐ Anemia	☐ Arthritis	☐ Asthma
☐ Back Problems	☐ Cancer	☐ Cold Sores
☐ COPD	☐ Dementia	☐ Dental Appt. Pre Med
☐ Depression/Anxiety	☐ Diabetes	☐ Domestic Violence
☐ Eating Disorder	☐ Epilepsy/Seizures	☐ Fainting
☐ Hearing Aids	☐ Heart Attack	☐ Heart Surgery
☐ Hepatitis A / B / C (circle)	☐ High Blood Pressure	☐ Joint Replacement
☐ Mental Health Issues	☐ Obstructive Sleep Apnea	☐ Osteoporosis
☐ Pacemaker	☐ STD/STI	☐ Stroke
☐ Thyroid Disease	☐ Transplant Recipient/Donor	☐ TMJ Problems
☐ Tuberculosis	☐ Other: _____	

Please list your medications, dosage, and use

Medication:	Dosage:	Use:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list ALL allergies: _____

_____

_____

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MEDICAL HISTORY AND INFORMATION

For the following, circle Yes or No, or fill in the blank where applicable:

Do you smoke cigarettes/cigars? Yes No
Do you use an e-cigarette? Yes No
Do you chew tobacco? Yes No
Do you use cannabis (marijuana)? Yes No
Do you use any other form of recreational drugs? Yes No Which ones?_____
How many alcohol beverages do you consume each week? _____

What is your quality of sleep like? _____
Do you wake up to use the washroom? Yes No
Do you wake up gasping? Yes No
Do you wake up with acid in your mouth? Yes No
Does your partner complain of snoring? Yes No
Would you be interested in an Obstructive Sleep Apnea screening? Yes No

FOR WOMEN ONLY:
Are you taking Birth Control Pills or other Contraceptives? Yes No
Are you currently Pregnant? Yes No If yes, how many months? _____
Are you currently breast-feeding? Yes No

How would you rate your level of nervousness at the dentist? (1 not at all nervous to 5 very nervous)
Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very

Terms and conditions (sign on following page)

Appointments:
Please help us maintain the operation of our office on sound principle so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore we will need at least 48 HOURS NOTICE to be given if cancellation is necessary. No show or last minute cancellations can result in a $100 cancellation fee.

Payment of Fees:
This office is willing to accept direct payment from your dental plan for services which your plan covers. If your dental plan does not cover the full cost of your treatment, you will be responsible for any difference between the amount paid by your plan and the amount charged. Your portion is then due and payable on the day of your appointment. You are responsible for providing necessary information in order for us to direct bill your insurance company as well as informing us of any changes in this information.

General Release:
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 also authorize the communication of information related to the coverage of serviced described in this form to the named doctor.

Consent:
I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated and consent to the use of local anesthetic agents. I understand the above statements regarding payment of fees and accept the responsibility for payment for dental services provided by myself or my dependents, due and payable when services are rendered unless other financial arrangements have been made.

Personal Information Consent

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 summarized 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, addresses, phone numbers, and email addresses. (Collectively referred to as "Contact Information"). Contacted is collected and 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 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 examination or treatment
- To send patients informational material about our dental practice, and condolences or congratulation messages.

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.

We collect information from out 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 purposed of diagnosing dental conditions and providing dental treatment.

Patients' 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 referred by us to the other dentist or dental specialist for treatment
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment

Dentists in Alberta 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 interest.

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

Signature: _____ Date: _____

✔ I accept this as my electronic signature for the purpose of this form

Stony Plain Dental Centre - Understanding your Insurance Coverage and Payment Options

If you do not have insurance

If you do not have insurance, you are responsible to pay the full cost of your dental treatment following your appointment. At Stony Plain Dental Centre, we offer a financing option, HealthSmart, that may be an option for you.

Financing option: PayBright

PayBright is a financing option starting at 0% interest. You are able to apply within the office with your drivers license. Please ask the front desk if you are interested in this option, they can give you more information, explain the process and requirements, and get you set up.

If you have insurance

Welcome to Stony Plain Dental Centre. Our office is pleased to offer assistance in submitting your dental claims. We can do this in one of two ways, assignment or non-assignment.

Non-Assignment - Non-Assignment means you are responsible for paying the cost of your dental treatment after each appointment. We are happy to process the all of the paperwork for you, normally electronically, and submit it directly to your insurance company. The insurance company will then pay you back directly, some within 24 to 48 hours. This option is beneficial as it allows you to keep track of your yearly maximum.

Assignment - Assignment means our office will bill directly to your insurance company. With this option, you are responsible to pay any remaining balance (any amount that your insurance plan does not cover). You are also responsible for knowing what your yearly maximum is and what is remaining on it. Most major insurance companies have a free app for your phone that allows you to keep track of your yearly maximum. We do not have access to this information as it is private information between you and your insurance compnay.

Insurance plans typically do not pay 100% - You are required to pay the difference.

Your dental insurance plan may not match(pay) all dental fees. Therefore, there is an amount remaining that you are responsible to pay immediately after the insurance payment is recieved. We ensure your fees are competitive with the area and also reflect the quality of service our staff and dentists provide.

At Stony Plain Dental Centre, we will accept all insurance plans, provided they will make payment directly to the dentist. We work with the majority of insurance plans and are willing to send pre-authorizations for further treatment when requested by you. Please remember these preauthorizations are only **estimates**, as treatment may change acoording to the needs of the patient. Please also be advised that most insurance companies will only give a payment estimate directly to the policy holder; therefore, we may not be able to obtain this information for you.

I have read and understand Stony Plain Dental Centre's Policy with payment requirements and for billing my insurance company.

Patient Signature: _____ Date: _____

✔ I accept this as my electronic signature for the purpose of this form

Patient Insurance Information

Because of privacy, your insurance does not give us the following information. Please complete the the known information about your insurance policy. If you do not know this information, please sign the bottom of this page.

Yearly Max: _____ ☐ Unlimited

Year End: _____ (i.e., December 31)

% Coverage: _____ ☐ 80% ☐ 100%

How much is used to date: _____ Date: _____

Major Coverage: _____ ☐ Unlimited

% Coverage for Major: _____ ☐ 50% ☐ 80% ☐ 100%

How much Major used to date: _____

I am covered for:

New Patient Exam ☐ Yes ☐ No If no, when is next new patient exam? _____

Panoramic X-ray ☐ Yes ☐ No If no, when is next panoramic x-ray? _____

Crowns ☐ Yes ☐ No If yes, how much coverage? _____

Units of scaling per year: _____ Units ☐ Unlimited

I understand that any unpaid balance is my responsibility to pay.

I understnad the financial policy of Stony Plain Dental Centre and that I will be presented a receipt for all transactions processed.

I have read and understand all information regarding Stony Plain Dental Centre's financial policy information, and certify, to my knowledge, that the information I have provided is accurate.

Patient (or parent if under 18) Signature: _____ Date: _____

✔ I accept this as my electronic signature for the purpose of this form