Welcome to South 40 Dental! – Tell Us About Yourself

Name: ____
Last First MI Title

Preferred Name:______________________________ ❑ Male ❑ Female

Parent/Guardian Name if Under 18 Years Old: ______________________________

Address: ______________________City ______________Prov. _______Postal Code________

Date of Birth (day)______ (Month)______ (Year)_________

Home Phone:_______________________ Work Phone:_______________________

Cell Phone:_______________________ E-mail Address: _______________________

Employer:_______________________ Occupation: _______________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Domestic Partner

How did you hear about our office?______________________________

Do you prefer to be contacted for appointment confirmation via: E-mail or phone or Text? (Please circle preference)

■ Insurance – Primary ■

Subscriber Name: ____________________ Relationship to Patient: ___________Subscriber DOB: ___________

Subscriber Employer: ____________________ Insurance Company Name: ____________________

Group Number: ______________ Subscriber ID: ____________________

■ Insurance – Secondary ■

Subscriber Name: ____________________ Relationship to Patient:______________ Subscriber DOB:_____________

Subscriber Employer: ____________________

Insurance Company Name: ____________________

Group Number: ______________ Subscriber ID: ____________________

■ Assignment and Release (For Direct Billing)

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to South 40 Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Policy Holders Signature: ______________________________

Relationship to plan member: ❑ Self ❑ Spouse ❑ Child Date: ____________________

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient or Parent/Guardian Signature:______________________________

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name:____

Physician's Phone: ________________________ Date of last Visit: _______________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ____

Do you use tobacco in any form? ❑ Yes ❑ No

Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No

Are you taking any medications? ❑ Yes ❑No

Please list each one: ____

Have you ever had any surgical procedures? ❑ Yes ❑ No

Please list each one: ____

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
❑	❑	Abnormal Bleeding	❑	❑	Glaucoma	❑	❑	Sickle Cell Disease
❑	❑	Alcohol Abuse	❑	❑	HIV+ AIDS	❑	❑	Sinus Problems
❑	❑	Allergies	❑	❑	Heart Attack	❑	❑	Stroke
❑	❑	Anemia	❑	❑	Heart Murmur	❑	❑	Thyroid Problems
❑	❑	Angina Pectoris	❑	❑	Heart Surgery	❑	❑	Tuberculosis
❑	❑	Arthritis	❑	❑	Hemophilia	❑	❑	Ulcers
❑	❑	Artificial Heart Valve	❑	❑	Hepatitis A, B or C			
❑	❑	Asthma	❑	❑	High Blood Pressure			
❑	❑	Cancer	❑	❑	Joint Replacement			
❑	❑	Chemotherapy	❑	❑	Kidney Problems			
❑	❑	Congenital Heart Defect	❑	❑	Liver Disease			
❑	❑	Diabetes	❑	❑	Low Blood Pressure			
❑	❑	Difficulty Breathing	❑	❑	Mitral Valve Prolapse			
❑	❑	Drug Abuse	❑	❑	Pace Maker			
❑	❑	Emphysema	❑	❑	Psychiatric Problems			
❑	❑	Epilepsy	❑	❑	Radiation Therapy			
❑	❑	Facial Surgery	❑	❑	Seizures			
❑	❑	Fainting Spells	❑	❑	Shingles			
❑	❑	Frequent Headaches						

Yes	No	Allergies
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Jewelry
❑	❑	Latex
❑	❑	Metals
❑	❑	Penicillin
❑	❑	Tetracycline
❑	❑	Other ____________

Yes	No	If Female, Please Answer
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If so, # of Weeks _____
❑	❑	Are you nursing

Any other medical issues? (Please list) ________________________________

Nearest relative not living with you:
Name: ________________________________ Phone: ____________________

Relationship__________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:____Date: ____________________________

Dental History

How may we help you today? ____

Your CURRENT dental health is: ❑ Good ❑ Fair ❑ Poor

Do you REQUIRE ANTIBIOTICS before dental treatment? ❑ Yes ❑ No

Are you having PAIN, SWELLING or SORE SPOTS at this time? ❑ Yes ❑ No

Have you ever had GUM TREATMENT? ❑ Yes ❑ No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ) ❑ Yes ❑ No

Are you MISSING any teeth? ❑ Yes ❑ No Do your GUMS BLEED? ❑ Yes ❑ No

On a scale of 1 to 10, how would you rate your SMILE? (1 being lowest, 10 highest) 1 2 3 4 5 6 7 8 9 10

Have you ever had **BOTOX®** or other facial cosmetic treatment in the past? ❑ Yes ❑ No

Would you be interested in **BOTOX®** treatment? ❑ Yes ❑ No

If you SNORE, would you like an oral device to help you stop snoring? ❑ Yes ❑ No

How often do you: FLOSS_______________________ BRUSH?______________

Are your teeth SENSITIVE to heat, cold or anything else? ❑ Yes ❑No

Have you ever had any COMPLICATIONS with any previous dental work? ❑ Yes ❑ No

Do you have a FEAR of the Dentist? ❑ Yes ❑ No If yes, please check: ❑mild ❑moderate ❑severe

Have you ever had any unfavorable dental EXPERIENCE? ❑ Yes ❑ No

When was your last dental CLEANING?__________________ When was your last dental VISIT?_________________

Why did you leave your previous dentist?____

How can we ACCOMODATE you better during your dental visit? ____

Here at South 40 Dental we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Dental Implants	Veneers/Lumineers (Cosmetics)	Invisalign
Six Month Adult Cosmetic Braces	Smile Makeover	Tooth Coloured Fillings(Composite)
Sedation Dentistry	Crown and Bridge	Wisdom Teeth Extractions
Partials and Complete Dentures	Night/Sport Guards	Teeth Whitening

FINANCIAL AGREEMENT

Payment options

We offer the following payment options: Cash, Debit, Visa, MasterCard, Money order, and Dental Card Financing. Payment plans *may* be an option. **We require you to pay your estimated portion at each visit**. If you would like to discuss financial arrangements/financing options, please speak with one of our team members ***and ensure it is arranged in advance of your treatment.***

Dental Insurance Benefits

We want you to get the most out of your dental plan benefits. Our team will work with you to maximize your yearly limits and submit pre authorizations for major restorative work. It is your responsibility to ensure all information provided to us and your insurance company is correct and up to date. We will be unable to submit or collect on your behalf if the information on file is not correct.

- I therefore fully understand that quoted costs are estimates only, and the patient portion are subject to change if changes are made to the treatment plan or if insurance pays more or less than estimated and we base the estimates on the information provided to us by your plan.

If your plan accepts assignment of benefits and electronic claims, you will only be responsible for the portion of your treatment that your plan did not cover. **Some plans base the amount eligible on a fee schedule determined by insurance companies, so you may receive a lower percentage than the reimbursement level indicated in your dental plan. For example, if your plan states that it will pay 90% of the cost of a procedure, it means 90% of the fee determined by the insurance company, not the actual fee charged by our clinic.**

- I hereby authorize my insurance company to make payments directly to this dental office for benefits.

Some dental policies will not pay us directly, therefore we will submit the claims on your behalf, but you will be responsible for 100% of the fees *at the time of treatment*, and will receive reimbursement from your plan based on your dental plan fee schedule. If at any time your dental plan/benefits change, please notify us immediately.

- I understand that I am responsible for all charges whether or not they are covered by insurance.

- I authorize this office to credit or charge my credit card for any balances or credits resulting after insurance payments have been processed. If such charge over $100 is necessary, I require this office to notify me before the charge is made. This does not apply to pre-arranged financial agreements on my account.

Name (as it appears on the card) ____

Credit Card # ____ Expiration Date ______________________

○ VISA ○ MASTERCARD **Please be advised Visa Debit and American Express are not accepted forms of payment

I have read, and understand and agree to all terms as above. I agree to pay all service charges that may be incurred should any balances remain unpaid after treatment.

X____ Date______________________

(Signature of responsible party)

NEW PATIENT

PRIVACY, DISCLOSURE, & CONSENT

TO: South 40 Dental Sexsmith and South 40 Health Services

Information for our Patients
At South 40 Dental Sexsmith, all professional dental services are performed by licensed members of the Alberta Dental Association and College ("Dental Professionals"), and all institutional health care services are performed independently by South 40 Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. South 40 Dental Sexsmith and South 40 Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in South 40 Health Services.

Privacy Act and Consent to Treatment
By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for South 40 Dental Sexsmith; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of South 40 Dental Sexsmith to provide the services you are requesting.

Acknowledgement regarding Information Provided
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 have had the opportunity to ask questions and receive answers regarding my medical – dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office**. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among South 40 Dental Sexsmith, and South 40 Health Services my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by South 40 Dental Sexsmith and South 40 Health Services in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that the South 40 Dental Sexsmith and South 40 Health Services are relying upon the information which I have provided being accurate and complete

______________________________________	______________________________________	________________
Print Name of ❑Patient ❑Parent ❑ Guardian	Signature of ❑Patient ❑Parent ❑Guardian	Date

_________________________________	_______________
Reviewed by South 40 Dental Sexsmith	Date