Calgary Dental House Medical History

Name:	Family Dr:	Date:

Yes	No	
		Are you being treated for any medical condition at present or within the past 2 years? If yes, please explain.
		Have you been hospitalized within the past 2 years? If so, why?
		Have you had a complete medical examination within the past year? If so, when?
		Have you recently, or are you presently taking Prescription or Non-Prescription drugs? If yes, please list, or provide the receptionist with a medications print out from your Pharmacist.
		Have you ever reacted adversely to any of the following: Antibiotics, Penicillin, Sulfonamide, other antibiotics, Aspirin, Barbiturates (sleeping pills), Codeine, Darvon, Local Anesthetic (freezing), Nitrous Oxide, or any other medicine? Please explain.
		Have you ever been advised against taking any specific type of medicine? If yes, please explain.
		Do you have any of the following: Asthma, Hay Fever, Food Allergies, Metal or Latex allergies, Skin Rashes, Hives, or any other allergic conditions?
		Do you smoke or use any other form of tobacco? If yes, how much?
		Are you wearing the transdermal nicotine patch?
		Are you alcohol and / or drug dependent?
		Have you ever received treatment for alcohol and / or drug dependency?

Calgary Dental House Medical History

Name:	Family Dr:	Date:

Yes	No	
		Indicate which of the following you presently have or ever had: A.I.D.S, Abnormal Pap Smear, Anemia, Arthritis / Rheumatism, Artificial Joints, Blood Disorders, Bronchitis, Cancer, Circulation Problems, Congenital Heart Problems, Cortisone / Steroid treatment, Diabetes, Emphysema, Epilepsy / Seizures, Fainting / Dizzy Spells, Glandular Disorders, Glaucoma, Head / Neck Injuries, Heart Attack or Disease, Heart Pacemaker, Heart Rhythm Disorder, Heart Surgery, Hepatitis A, B or C, Herpes, High / Low Blood Pressure, Hodgkin's Disease, Hyperglycemia / Hypoglycemia, Hypertension, HPV, Jaundice, Kidney Disease, Liver Disease, Lung Disease, Malignant Hyperthermia, Mitral Valve Prolapse, Multiple Sclerosis, Organ Transplant / Implant, Parkinson's , Psychiatric Treatment, Radiation Treatment, Rheumatic / Scarlet Fever, Sickle Cell Disease, Sinus Trouble, Stomach / Intestine Problems, Stroke, Thyroid Disease, Tuberculosis, Ulcers, Venereal Disease, Other?
		WOMEN ONLY: Are you pregnant or suspect you may be? If yes, what month?
		WOMEN ONLY: Are you taking Birth Control Pills? If yes, what kind?
		Do you currently have, or have you ever had in the past, any disease, condition or problem not listed above?
		Is there anything else about your health that we should be made aware of?
		Do you wish to speak to the dentist privately about any problem or medical condition?

CALGARY DENTAL HOUSE

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Unit 112, 971 64th Avenue
Calgary, AB T2E 7P4

New Patient Office Policy Agreement

The *New Patient Office Policy Agreement* states rules and regulations for Calgary Dental House. The Sections listed below indicate what actions are taken during instances of late or no show appointments and payment options for our patients. Calgary Dental House has flexible and a wide variety of operational hours. We understand that every patient has a unique schedule; ensuring we do our best to accommodate each and every patient's agenda. In return, we do expect our patients to respect the time and effort that goes into each scheduled appointment. In an event where you are unable to make your appointment, we do require a minimum 24 hour notice. This is to ensure that we can schedule an appointment for patients in need of urgent treatment.

SECTION A) APPOINTMENTS:

I, <<Patient First Name>> <<Patient Last Name>>, understand that any appointment I schedule with Calgary Dental House, is considered confirmed at the time of booking. As a friendly reminder, Calgary Dental House will call 48 hours prior, to ensure appointment confirmation. My scheduled appointment reserves services provided by the Dr and/or Hygienist. If for any reason, you must cancel or reschedule my appointment, we ask you do at the time of confirmation or prior to with a minimum of a 24 hour notice.

SECTION B) NO SHOW APPOINTMENTS:

Calgary Dental House guarantees a 48 hour confirmation call for scheduled appointments. In a case where a voice message is left and the patient fails to respond, the appointment is still considered scheduled and confirmed unless otherwise stated by the patient. A patient that does not show up for their scheduled appointment without 24 hour notice, is considered a no-show appointment. I, <<Patient First Name>> <<Patient Last Name>>, understand that in an event of a no-show appointment, this information will be recorded in my patient file, and can result in a penalty fee of up to $50.00. The appointment length will be assessed and put into consideration. After three no-show appointments, a deposit of 10% of the total cost for scheduled treatment must be made at time of booking. Once a payment is made by your insurance company, a refund will be made to you by cheque if necessary or if you wish, you may also keep a credit on file.

SECTION C) PAYMENT POLICY:

Calgary Dental House is an assignment practice and we offer direct billing for the accommodation for our patients. As financial protection for our office, we ask that we keep a credit card on file. The credit card on file will not be processed without verbal or written consent from the card holder up to 60 days. In a case where the patient balance is 61 - 90 days past due and communication has been attempted numerous times, the credit card on file will be processed. If payment is still not made after 90 + days past due, the account will be sent to a collection agency. Our office must be notified as soon as possible if any changes or updates are made in your insurance plan as your insurance provider does not inform us. As a courtesy to you, Calgary Dental House will accept payment directly from your insurance company for your dental care where the following conditions are met:

An active credit card must be kept on file.

Uninsured payments must be paid in full on the date of service.

You will be notified if your dental insurance provider is inactive with payment 60 days following treatment by our practice.

If your insurance provider does not respond with payment after 90 days following treatment, you are held completely responsible for the outstanding balance. Please note that by this time we have contacted your insurance provider minimum of 3 times.

Please understand that each insurance plan for each patient has its own exceptions and limitations. While our office strives to give a thorough explanation of insurance coverage, as a provider, we are limited to the information we can access. Therefore, I, <<Patient First Name>> <<Patient Last Name>>, understand that I must be well-informed of my dental benefits.

Unless other arrangements have been made, we require payment in full on date of service and a credit card on file for patients who would like to do direct billing or do not have dental insurance. If there is any outstanding charges on your account, payment is expected in full prior to your next appointment. If full payment is not made your appointment will be rescheduled until payment has been received.

I, <<Patient First Name>> <<Patient Last Name>>, have read and understand section A, B, and C of the Calgary Dental House New Patient Office Policy Agreement. I understand that Calgary Dental House requires a minimum of 24 hour notice for cancellation and understand the consequences listed above in the event of a no show appointment. I, <<Patient First Name>> <<Patient Last Name>>, understand I must be well informed of my own dental benefits. If I do not have dental insurance, a credit card must be on file and I am completely responsible for payment in full on date of service.

PERSONAL INFORMATION PRIVACY ACT (PIPA) CONSENT FORM

Our office staff understands the importance of protecting your personal information and we are committed to collecting, using, and disclosing your personal information responsibly. We will only collect, use, and share the information contained in your dental records, including personal information, photos, x-rays, and clinical information, as is reasonably necessary for the following:

To communicate with other health care providers, including specialists, general dentists, and doctors as it pertains to your health care or for lawful identification purpose.

For Dr. Crawford and Dr. Reddy's research, dental health promotion, education and study between colleagues and with dental patients. Your name will remain confidential.

To obtain information from your dental plan insurance provider on dental coverage and benefits for the purpose of assisting you with estimates, pre-authorizations for treatment, claims, and accepting assignment of payment for claims on your behalf.

For the purpose of billing and maintaining contact with our patients.

I, <<Patient First Name>> <<Patient Last Name>>, consent to the collection, use, and disclosure of my personal information as set out above and this consent shall continue in effect until the undersigned revokes the same.

Patient Name: <<Patient First Name>> <<Patient Last Name>>

Date: <<Date>>