SKY DENTAL Patient Personal and Insurance Information Form

Title _____ Given Name _____ Pronunciation _____

Surname _____ Preferred Name _____

Address _____

Province _____ Postal Code _____ Date of Birth mm / dd / yy _____ Gender _____

City _____ Email _____ Occupation _____ Employer/School _____

Home # _____ Work # _____ Other # _____ Contact Method _____

Emergency Contact _____ Phone _____ Relationship _____

Would you like to be contacted for short-notice appointments? ☐ Y ☐ N How did you hear about us? _____

DENTAL INFORMATION

Do your gums bleed when brushing or flossing? Yes ☐

Does food frequently get caught in your teeth? Yes ☐

Are your teeth sensitive to cold, hot, sweets, or pressure? Yes ☐

Do you feel pain in any of your teeth? Yes ☐

Are you happy with the appearance of your teeth?
If not, please explain. ☐ Y ☐ N

On a scale of 1-5, how nervous are you about visiting the dentist (circle one)?
Not Nervous 1 2 3 4 5 Very Nervous

Date of last teeth cleaning

Date of last dental exam

If you have a current dental problem, please describe:

Do you have any other concerns about having dental treatment?
If so, please explain.

What can we do to make you smile? Check all that apply and we'll get back to you with more information about your inquiry.

- ☐ Veneers
- ☐ Gummy Smile
- ☐ Eliminate Gaps
- ☐ Total Smile Makeovers
- ☐ Oral Conscious Sedation
- ☐ Nitrous Oxide (laughing gas)
- ☐ Replace Missing Teeth
- ☐ Replace Metal Fillings
- ☐ Cosmetic Dentures
- ☐ Sleep Apnea/Snoring
- ☐ Fix Broken/Cracked Teeth
- ☐ Dental Implants
- ☐ White Fillings
- ☐ Teeth Whitening

MEDICAL INFORMATION

Dental professionals primarily treat the area in and around your mouth, but since your mouth is part of your body, your medical history and current medications have an important relationship with your dental treatment. Please answer the following questions.

Are you currently seeing a General Physician?
Please provide their name, practice name, and phone number. ☐ Y ☐ N

Have you recently (in the last two years) been hospitalized or had a major operation? Please explain. ☐ Y ☐ N

Are you or could you be pregnant? ☐ Y ☐ N If yes, what is the expected delivery date? Taking birth control pills? ☐ Y ☐ N

SKY DENTAL CLINIC
830 Parsons Road SW
Edmonton, AB T6X 0B4
780.485.0562
reception@skydentalclinic.ca

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Please check if you have experienced one of the following.

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Circulation Problems
- ☐ COPD
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head or Neck Injuries
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemakers
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mental/Nervous Disorder
- ☐ Organ/Medical Transplant
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ Tuberculosis

Please list any prescription or non-prescription **MEDICATIONS** you are taking or have recently taken.

Please enter details / additional information.

Are you on blood thinners (Warfarin, Eliquis, Pradaxa)? ☐ Y ☐ N

Do you bruise easily or bleed severely when you are cut? ☐ Y ☐ N

Do you have severe earaches, ear or throat infections, or headaches? ☐ Y ☐ N

Do you smoke? If so, how many per day for how many years? _____

If you have any allergic conditions please list them below. This can include asthma, hay fever, food allergies, and metal or latex allergies.

INSURANCE INFORMATION, CLAIM AUTHORIZATION AND FINANCIAL CONSENT

PRIMARY INSURANCE

Subscriber Name _____ **Relationship**

Insurance Name _____ **Subscriber's DOB** _____

Policy Number _____

Subscriber ID Number _____

SECONDARY INSURANCE

Subscriber Name _____ **Relationship**

Insurance Name _____ **Subscriber's DOB** _____

Policy Number _____ _____

Subscriber ID Number _____

I authorize Sky Dental Clinic to submit claims on my behalf and have my insurance company pay the office directly. I authorize the release, to my dental benefit carrier and CDA, of information contained in claims submitted electronically. I understand this is a service provided by my dental provider, but it is ultimately my responsibility to know information pertaining to my insurance policy. I understand I am required to pay the remaining balance not paid for by my insurance policy.

Name _____ Date _____ Signature _____

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SKY DENTAL Patient Personal Information Consent Waiver

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 summarizes 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, home addresses, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses. (Collectively referred to us "Contact Information"). Contact Information 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 the reminders to the patients concerning the need for further dental examination or treatment.
- To send patients informational material about our dental practice.

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 is collected for payment processing purposes. It is not shared with third parties without your consent, unless permitted by law for outstanding bill collection purposes.

We collect information from our 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 purpose 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.
- With the consent of the patient, to other dentists and dental specialists, or to other health care professionals.
- If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access to patient information, as part of the due diligence process, in order to verify information important to the potential sale. If this occurs, we will take step to ensure that the prospective purchaser safeguards all personal information

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

Name _____ Date _____ Signature _____

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