SETON FAMILY
DENTAL CENTRE

Name: *(First)*	*(Last)*		(*Preferred)*		
Birthdate: (Month)	(Day)	(Year)	**Gender**:	Male	Female
Address:					
City:		**Prov:**	**Postal Code:**		
Cell Phone:		**(Number will be used for confirmation of appointments)**			
Email Address:		**(Email will be used for electronic communication)**			
Emergency Contact Name:		**Relation:**	**Phone:**		
Whom may we thank for your referral?	Friend/Co-worker: _____	Family member: _____			

DENTAL QUESTIONNAIRE

Previous dentist name or dental office:

When was your last dental visit:	6 months	1 year	2 years	3 years +
When were your last x-rays taken:	6 months	1 year	2 years	3 years +
When was your last dental cleaning:	6 months	1 year	2 years	3 years +

Are you currently in any discomfort/pain with your teeth or gums?	No	Yes
Do your gums ever bleed?	No	Yes
Have you ever fainted or had complications following dental treatment?	No	Yes
Have you ever had an injury, surgery, or x-ray therapy to the face or jaw?	No	Yes
Do you have any pain in your jaw?	No	Yes
Do you clench or grind your teeth?	No	Yes
Are you unhappy with your smile?	No	Yes
Would you like to have straighter teeth?	No	Yes
Would you like to have whiter teeth?	No	Yes

Nervous or anxious about dental treatment?	No	Mild	Moderate	Severe
How would you describe the current condition of your oral health?	Poor	Fair	Good	Excellent

MEDICAL QUESTIONNAIRE

Please check all that apply to you:

__AIDS/HIV
__ALCOHOL OR DRUG ABUSE
__ANEMIA
__ARTHRITIS
__ARTICIFIAL VALVES/JOINTS/PINS
__ASTHMA (INHALER Y/N)
__BLOOD DISORDER/TRANSFUSION
__CANCER/CHEMOTHERAPY
__CONGESTIVE HEART FAILURE
__DIABETES (INSULIN Y/N)
__DIZZINESS/FAINTING
__EPILEPSY
__EXCESSIVE BLEEDING
__GLAUCOMA
__GROWTHS OR TUMORS
__HEAD INJURIES
__HEART DISEASE
__HEART MURMUR
__HEPATITIS (TYPE_____)
__HIGH/LOW BLOOD PRESSURE
__JAUNDICE
__KIDNEY DISEASE
__LIVER DISEASE
__MENTAL/NERVOUS DISORDER
__PACEMAKER
__RADIATION TREATMENT
__RESPIRATORY PROBLEMS
__RHEUMATIC FEVER
__SINUS PROBLEMS
__SMOKER
__STD/VENEREAL DISEASE
__STOMACH PROBLEMS
__STROKE
__THYROID DISEASE
__TMJ PROBLEMS
__TUBERCULOSIS
__ULCER

PREGNANT (Y/N) BREASTFEEDING (Y/N) BIRTH CONTROL (Y/N)

Do you require PREMEDICATION such as antibiotic coverage for dental treatment due to a heart condition and/or artificial joints? No Yes

Do you have ALLERGIES to?

__ASPIRIN
__LATEX
__TYLENOL
__SEASONAL
__CODEINE/MORPHINE
__ANTIBIOTICS: _____
__SPECIFIC FOOD: _____
__OTHER: _____

Family Doctor: _____ Phone: _____

Have you been under the care of a physician recently? *Explain* _____

Have you been admitted to a hospital for major surgery in the last 2 years? *Explain* _____

Have you ever had an infectious disease? Y/N
Have you ever travelled to an area with infectious disease? Y/N

List all medications, pills, vitamins or herbs you are presently taking:

_____ For _____
_____ For _____
_____ For _____
_____ For _____
_____ For _____
_____ For _____
_____ For _____
_____ For _____

Welcome to Seton Family Dental Centre!

Our Appointment Policy

Thank you for allowing us the privilege of being your dental health provider. Our practice is dedicated to quality care and is pleased to reserve time exclusively for each patient.

We respect our patients' time and make every effort to remain on schedule. Despite careful scheduling, dental emergencies can cause delays. If your appointment time is affected due to an unforeseen emergency, we will try our best to notify you in advance. We know that your time, like our doctor's, is valuable and we will make every effort to see you on time and will ensure you are given the same time and attention for your dental health.

Because we reserve time exclusively for you, we ask that you make every effort to keep your reserved appointment time. If you find that you cannot keep your scheduled visit, **we require a minimum of 2 business days' notification**. Advance notice allows our office to see other patients who may have been waiting to see us for necessary treatment. We thank you in advance for your consideration**. A charge of $75.00 will apply to your account if sufficient notice is not provided. This charge is at the discretion of your doctor.**

Consent for Treatment/Accountability Confirmation

To the best of my knowledge all of the preceding answers and information provided are true, complete and accurate. I grant permission to you and your assignees to telephone or e-mail me to discuss matters related to this form. I understand that this information is held in the strictest confidence and it is my responsibility to inform the office of any changes to my medical status. I authorize the dental office to perform any necessary dental services that I may need during diagnosis and treatment with my written or verbal informed consent.
I, the undersigned, clearly understand all policies of Seton Family Dental Centre. I understand and agree to pay all fees associated with my dental treatment. With or without dental coverage, I agree to make myself aware of those fees prior to any dental treatment I authorize to be done.

_____	_____	_____
Signature of Patient/Guardian	Printed Name	Date

Financial Policies for Dental Patients

Your dental insurance policy is an agreement between you and your insurance company, and we will be happy to assist you in preparing and sending in the necessary forms. Please remember that no insurance company attempts to cover all dental costs. We cannot render dental treatment on the assumption that our dental fees will be paid in full by an insurance company. Full payment to our office remains your responsibility, regardless of how much your insurance does or does not pay.

I am aware that Seton Family Dental Centre direct bills my insurance company as a courtesy to me and that in doing so, the dental office accepts no responsibility for any uncovered amounts, amounts over benefit maximums, limitations or plan restrictions, etc. I understand that the dental office collects my dental coverage information as a guideline only to assist me in maximizing my benefits and this does not hold them responsible for my dental account. Seton Family Dental Centre advises that I make myself aware of my dental plan and eligible coverage and that I ask my dental team about any and all procedures I am authorizing.

Initial _____

Seton Family Dental Centre advises me to contact my plan administrator or insurance company for questions regarding eligible procedures and authorization of treatment. In addition, I am advised to make myself aware of all costs involved with my dental care. Seton Family Dental Centre advises me to keep track of my yearly maximums, limitations, appointment dates, and accumulated amounts used on my dental benefit plan.

Initial _____

Payment is due at the time of service. I am aware that if the dental office does not receive confirmation from my insurance for their exact payment, then Seton Family Dental Centre will estimate my portion at the time of visit. A statement of any unforeseen balance will be provided to me. I agree to pay all of these uncovered portions within **10 days** from the date of statement or interest charges of 5% per month may be applied to my account. I agree to pay these interest charges if applied to my overdue account.

Initial _____

I also understand that any uncovered procedures that may have been done at another dental office are my responsibility. IMPORTANT: Please be advised that complete oral examinations (new patient exams) & x-ray coverage will be denied by your insurance if you have had this procedure completed at another dental office within the time limitations on your specific plan. You are responsible for this payment then in our office should this not be an eligible benefit with your coverage**.**

Initial _____

Financial Responsibility

I agree to the financial responsibility for any amounts not covered by my dental insurance to be applied to credit card below:

Credit Card (Circle one:) VISA MASTERCARD

Card Number: _____ Exp: _____

Name as it appears on the card: _____

Signature: _____ Today's Date: _____

Seton Family Dental Centre Personal Information Consent Form – Privacy Act Information

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 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, home/cell telephone numbers, and e-mail addresses. (Collectively referred to as "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 reminders to patients concerning the need for further dental examination or treatment
- To send patients informational material about our dental materials
- To follow up with treatment and/or customer services

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 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 for the following purposes:

- 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 dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion
- 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

If we are ever considering selling all or part of our dental practice, qualified, potential purchasers may be granted access, as part of the due diligence process, to patient information in order to verify information important to the potential sale. If this occurs, we will take steps 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.

_____	_____	_____
Signature of Patient/Guardian	Printed Name	Date