Name: _____

Address: _____ Postal Code: _____

Age:____ Birth Date: D/____ M/____ Y/____ Phone: _____ Bus: _____

Email address: _____ AHC #: _____

Referred or Recommended by: _____

Employer: _____

Insurance Information: _____

Spouse's Insurance: _____

Name: _____ Birth Date: D/____ M/____ Y/____

Present Denture Age: Upper - _____ Lower - _____
Personal Dentist: _____ Phone Number: _____
Personal Physician: _____ Phone Number: _____

MEDICAL HISTORY:

1. Yes No Are you in good health at the present time? _____
2. Yes No Are you under the care of a physician at the present time? _____
3. Yes No Are you on any medications at the present time? _____
4. Yes No Are you allergic to any medications? _____
5. Yes No Is there any history of family disease? What? _____
6. Do you have or have you had any of the following conditions? (PLEASE CHECK APPILICABLE CONDITIONS)

___ AIDS	___Chronic Headaches	___ Hepatitis	___ Rheumatic Fever
___Allergies	___ Diabetes	___ High/Low Blood Pressure	___ Sexually Transmitted Disease
___Anemia	___Dry Mouth	___HIV Infection	___Sinusitis
___Arthritis	___Epilepsy	___Kidney Disorder	___Stroke
___Bleeding Disorder	___Facial Muscle Pain	___Menopause	___Thyroid Disorder
___Breathing Disorder	___Gastrointestinal Disorder	___Mental/Nervous Disorder	___Tuberculosis
___Cancer	___Heart Disease	___Migraine Headaches	___Other_____

7. Yes No Do you smoke or use chewing tobacco? _____
8. Yes No Have you ever had x-ray for tumor of growth in your head, neck, or mouth? _____
9. Yes No Have you had serious injury, surgery or therapy to your head, neck, or mouth? _____
10. Yes No Do you bruise easily, or bleed abnormally? _____
11. Yes No Are you pregnant? _____
12. Yes No Have you had a recent change in weight? If yes, how much? _____
13. Yes No Are you on a diet? Personal Choice: _____ Physician's order: _____
14. Yes No Do you have any habits that may affect your teeth, such as clenching, grinding, nail biting, etc? _____

_____

I, the undersigned, herby certify the information given by me to be accurate, and I assume responsibility for all fees incurred.

Patient Signature: _____ Date: _____

Personal Information Protection Act Consent Form

In our office, we are dedicated to ensuring the protection of our patients' personal information and insuring that this information is used only in a professional manner. The following indicates some of the information that is collected, why we collect it, and when we may disclose your personal information. We collect, use and disclose your personal information where permitted or required by law.

Contact Information

We collect contact information from our patients such as full name, home address, home telephone number(s), work telephone number(s), cellular phone number(s). This information is considered as Contact Information and it is collected for a variety of purposes including the following:

- To open and update a patient file;
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts;
- To process claims for payment or reimbursement from a third-party health benefit provider or insurance company*
- To correspond by mail or by telephone to our patients regarding need for further examination or treatments; and
- To send correspondence to our patients regarding our clinic and practice.

* Contact information is/may be disclosed to a third party health benefit provider or insurance company when submitting a claim on the patients' behalf, for payment or reimbursement of all or part of the cost of the treatment provided, or when a patient has requested a preauthorization of a proposed treatment.

Medical/Dental History

We collect from our patients, information about their health history, family health history, physical and mental condition, their dental health history and family dental health history. This Medical/Dental information is collected for a variety of purposes and may be used in part to assist us in diagnosing dental conditions and providing appropriate treatment for you, and may be disclosed for the following purposes:

- To a third-party health benefit provider or insurance company, in the submission of a claim on behalf of the patient, for reimbursement of payment of all or part of the cost of the treatment;
- To a third-party health benefit provider or insurance company on behalf of the patient, in the submission of a preauthorization of treatment;
- To other health/dental providers where, upon your consent, we are seeking a second opinion;
- To other health/dental providers where, upon your consent, we have referred you to additional/alternative treatment.

Future Use

If consideration to sell this practice or a portion of this practice ever occurs, and qualified potential purchasers may be granted access as part of due diligence process to patient information, in order to verify information related to the sale. If this ever occurs, we will take necessary steps to ensure that the prospective purchaser protects any personal information, as we have done.

Regulatory

The College of Alberta Denturists regulates all Denturists in the Province of Alberta, and as part of their regulatory function, may inspect our records and interview our staff in the process of their duties.

Consent

I hereby authorize and consent to the collection, use and disclosure of personal information concerning my self with regards to the above purposes.

Date at the City of _____, in the Province of Alberta on the _____day of _____, 20_____.

_____
(Patient Signature)

_____
(Print Name)

FINANCIAL POLICY

_____ Option 1 – Regular Claim:

All accounts are paid by you, at the time of service, and the insurance Claim (if any) is sent electronically (when possible) by our office at the time of your appointment. The insurance payment is mailed directly to you and may be received in as little as three days.

I, undersigned, hereby agree to the Financial Policy of Denture Clinic as outlined above.

____ Option 2 – Direct Billing:

For direct billing insurance providers, a credit card must be on file for outstanding amounts owing after insurance claims. Each insurance provider has fee guides to calculate your coverage. Insurance providers pay a percentage of their fee guide, not a percentage of our office fee guide. Because of this, it is impossible to estimate exactly how much your Insurance provider with reimburse you. We strive to accurately estimate for reimbursement; however, there may be a balance owing. For balances owing under $100, your card will be automatically charged. For balances over $100, we will attempt to contact you, and mail you a receipt with a copy of the Explanation of Benefits from your insurance provider.

I agree to the above financial policy and authorize Leduc Denture Clinic/River Valley Denture Clinic to apply any outstanding balance on my account, not covered by my insurance provider, to the credit card listed below:

Cardholder Name: _____

Authorization Signature: _____

Visa MasterCard

Card#_____CUV Code: _____Expires: _____M/Y

TREATMENT CONSENT

I, the undersigned authorize (Denture Clinic) to perform any necessary denture services that I may need during my diagnosis and treatment with my informed consent. I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. I also understand at any and all denture services are my sole responsibility and that I should make myself aware of any fees associated with my denture care prior to treatment.

Print: _____Signature: _____

Date: _____