ora dental

PATIENT NAME _____

Patient Information *(confidential)*

Birthdate (DD/MM/YYYY): _____ Sex (Please circle): M F Other Preferred pronouns: _____

Please circle your preferred contact #:

Home Ph: (_____)_____ Work Ph: (_____)_____ Cell Ph: (_____)_____

Address: _____

City: _____ Province: _____ Postal Code: _____ Email: _____

I can be best reached via: □ **Phone Call** □ **Text** □ **Email** □ **AM** □ **PM**

How did you find out about us? _____

Name of Physician: _____ Phone: (_____)_____

Person to Contact in Case of Emergency: _____ Phone: (_____)_____

Insurance Information *(please provide a copy of your insurance card)*

Name of Policy Holder _____ Birth date _____
Policy Holder's Employer _____
Name of Insurance Company _____ Group/Policy # _____ ID# _____

Do You Have Additional Insurance? □ Yes □ No If yes, please complete the following:
Name of Policy Holder _____ Birth date _____
Policy Holder's Employer _____
Name of Insurance Company _____ Group/Policy # _____ ID# _____

Patient Dental History

Name of Previous Dentist: _____ Date of Last Exam: _____

1. Do your gums bleed while brushing or flossing? □ Yes □ No
2. Are your teeth sensitive to hot or cold temperatures? □ Yes □ No
3. Are your teeth sensitive to sweet or sour liquids/foods? □ Yes □ No
4. Do you feel pain in any of your teeth? □ Yes □ No
5. Do you have any sores or lumps in or near your mouth? □ Yes □ No
6. Have you had any head or neck injuries? □ Yes □ No
7. Have you experienced any of the following problems in your jaw? □ Yes □ No

□ Clicking □ Difficulty in opening or closing □ Clench or grind your teeth
□ Pain (joint, ear, side of face) □ Difficulty in chewing

8. Do you have frequent headaches? □ Yes □ No
9. Have you had any difficult extractions in the past? □ Yes □ No
10. Have you ever had any prolonged bleeding following extractions? □ Yes □ No
11. Have you had any orthodontic (braces, Invisalign) treatment? □ Yes □ No
12. Do you wear dentures or partial dentures? □ Yes □ No
    If yes, date of placement _____
13. Have you ever received oral hygiene instructions for the care of your teeth and gums? □ Yes □ No
14. Do you feel nervous about having dental treatment? □ Yes □ No
    If yes, why? _____
15. Do you like your smile? □ Yes □ No

Please continue with the reverse side of this form.

Patient Medical History

1. Are you under medical treatment now? □ Yes □ No
2. Have you been hospitalized within the last 5years? □ Yes □ No
   If yes, please explain _____
3. Are you taking any medications including non-prescription medicine? □ Yes □ No
   If yes, what medications are you taking? _____
   (or, provide a copy of medication list) _____
   _____
4. Have you lost or gained more than 5 kg (10 lbs) in the past year? □ Yes □ No
5. When you walk up stairways, do you stop because of chest pain, shortness of breath? □ Yes □ No
6. Do your ankles swell during the day? □ Yes □ No
7. Are you on a special diet? □ Yes □ No
8. Do you have or have you had any of the following? □ Yes □ No

(If Yes, please check all that apply or write other conditions not listed)

- ○ Sinus Trouble
- ○ Arthritis
- ○ Cortisone Medication
- ○ Glaucoma
- ○ Sickle Cell Disease
- ○ Anemia
- ○ Hemophilia
- ○ Bruise Easily
- ○ Hepatitis A (infectious)
- ○ Hepatitis B (serum)
- ○ Hepatitis C
- ○ Liver Disease
- ○ Jaundice
- ○ Blood Transfusion
- ○ Drug Addiction
- ○ AIDS-HIV positive
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Diabetes □ Type I □ Type II
- ○ Radiation Therapy
- ○ Chemotherapy
- ○ Leukemia
- ○ Cancer
- ○ Epilepsy or Seizures
- ○ Fainting or Dizzy Spells
- ○ Nervousness
- ○ Psychiatric Treatment
- ○ Chest Pains (Angina Pectoris)
- ○ Easily Winded
- ○ Swollen Ankles
- ○ Heart Attack (Myocardial Infarction)
- ○ Artificial Heart Valve
- ○ Mitral Valve Prolapse
- ○ Congenital Heart Lesions
- ○ Heart Failure/Disease
- ○ Heart Surgery
- ○ Stroke
- ○ Heart Pacemaker
- ○ Artificial Joint Replacement
- ○ Rheumatic Fever
- ○ Ulcers
- ○ Stomach Troubles/GERD
- ○ Kidney Trouble
- ○ Thyroid Disease □ High □ Low
- ○ Emphysema/COPD
- ○ Tuberculosis
- ○ Asthma
- ○ Scarlet Fever
- ○ Cold Sores
- ○ STD / Venereal Disease
- ○ Hay Fever
- ○ Osteoporosis

Other:_____

9. Are you **allergic** to or have you had a reaction to any of the following: □ Yes □ No

(If Yes, please check all that apply)

- ○ Local Anesthetics (eg. Lidocaine)
- ○ Penicillin or Other Antibiotics
- ○ Sulfa Drugs
- ○ Barbiturates
- ○ Sedatives
- ○ Iodine
- ○ Aspirin
- ○ Codeine
- ○ Any Metals (eg. Nickel, mercury,etc.)
- ○ Latex Rubber

Other _____

10. **Women Only:**
Are you Pregnant or Nursing? □ Yes □ No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I acknowledge that I will be given the opportunity to discuss any treatment and can question the dentist concerning the nature, inherent risks, and the alternatives to any treatment, and will be given satisfactory answers. I am aware the practice of dentistry is not an exact science and acknowledge that no promises or guarantees of results have been made nor are expected. I hereby acknowledge that unforeseen conditions may arise during my treatment that may require a different procedure than originally discussed. I hereby authorize Dr. Chun to perform such procedures when, in his professional judgement, they may be necessary.

I authorize Ora Dental to send me correspondence (eg. appointment reminders) via Electronic Message (email, SMS, etc.)
□ **Yes** □ **No** **x**_____ (initials)

X_____ **Date** _____

Signature of patient (or guardian if minor)

Dental Insurance and Financial Agreement

We offer our new and existing patients flexibility in paying for dental treatment with the following options.
Please take a minute to review them, and decide which option works best for you.

□ Option 1: Non Assignment

This is the most popular option and by far the easiest! **You** will be in control of your insurance benefits, by paying in full for treatment at each appointment, and being reimbursed **directly** by your insurance company. This allows you to keep personal records of all dental transactions, insurance reimbursements, and to track how close you are to using your yearly maximum of benefits. You never have to worry about having outstanding account balances with us, and you will not have to come in to collect monies that we may owe to you due to any overpayment at your last visit. *Insurance companies typically reimburse patients within 1-3 business days after receiving the dental claim.* We can send electronic or manual claims for you at each appointment and assist you in any way we can in claim submissions.

I, _____, agree with the policies outlined in Option 1, and will sign below.

Signature of Patient or Responsible Party:_____ Date:_____

□ Option 2: Direct Billing

Direct Billing authorizes Ora Dental to Accept Assignment (Payment) of Benefits from your Insurance Carrier. It does not allow your insurance company to release any other information to us, due to the Health Privacy Act. We want to make you aware that we may experience some difficulty in communicating with your insurance company, and ask for your cooperation, understanding, and patience. Dental Providers usually receive insurance payments 2-3 weeks after date of service.

Once we receive the insurance cheque, there may be a credit or debit on your account. All accounts must balance zero within 30 days after insurance claim is paid to our office, therefore **we require a credit card to be left on file** in order to set your account balance to zero.

I agree with the policies outlined in Option 2, and will sign below authorizing Ora Dental to process a payment to set my outstanding account balance to "zero" by using the given credit card I have provided for any dental claim not paid by my insurance company within 30 days. A receipt for this transaction will be mailed with a paid statement. Please fill out the following requested information. This information will be kept confidential and used only upon the agreed terms.

I, _____, authorize Ora Dental to keep my signature on file and to issue a credit or debit memo to my credit card for any over and under payments once my insurance portion has been received. I understand this credit card will be held in all confidentiality and I will be contacted with any balance owing greater than $200.

Credit Card Number _____ Exp: _____ CVC:_____

Signature _____ Date _____

The following family members have my permission, under the same conditions noted above to use the credit card number for any and all charges incurred for dental treatment.

_____ _____

Financial Policy

At Ora Dental, we are committed to providing the best possible treatment for our patients. Our fees are reasonable, competitive, and generally follow the Alberta Dental Fee Guide established by the Alberta Dental Association. You are responsible for payment at the end of your dental visit regardless of your insurance company's determination of what is usual and customary unless other arrangements have been made. As a courtesy we will be happy to file your claims with the appropriate insurance company. When possible we will use electronic submission which will speed the process for you and you should receive your insurance reimbursement within a few short days. It is your responsibility to know and understand your dental benefits. As per Canadian Privacy Act Laws, it is you, as the policy holder, who is responsible for notifying us of any changes to your coverage, as well as knowing the various procedures covered under your plan to avoid disappointments with claim reimbursements. We will do our best to assist you with your claims. When appropriate we will file for an estimation of dental benefits for a treatment plan. But please keep in mind that insurance companies do not guarantee anything over the phone or in writing, and therefore any additional costs not covered by your insurance are your responsibility. Please be reminded that as health care providers we will order tests and radiographs as needed for proper diagnoses, and recommend ideal treatment and alternatives; we will not be dictated by what your insurance may/may not cover. By signing, you authorize Ora Dental to send & receive claims or information to your dental insurance provider via electronic submissions, mail or fax. This is also an authorization for your dependants. You are responsible for all fees for services provided the same day of service. A $25 fee will apply for any cheques returned due to insufficient funds from your financial institution.

Please note that we do require 2 business days' notice if you need to make any changes to your scheduled appointment. Failure to do so will result in a $50.00 short notice cancelation or missed appointment fee. We understand circumstances may vary.

We accept: Cash, Visa, MasterCard, and Debit.
Please let us know if you have any questions or concerns.

I, _____ , have read, understand and agree to this Financial Policy.

Signature of Patient or Responsible Party:_____ Date:_____

Personal Information Privacy Act

We are committed to protecting the privacy of our patients' personal information and to utilize all personal information in a responsible and professional manner and disclose personal information when permitted or required by law.

We collect contact, medical and financial information about our patients such as names, home/work addresses, home/work phone numbers, e-mail addresses, date of birth, insurance plan details, health/dental histories, emergency contact information.

* Contact information is disclosed to third party health benefit providers and insurance companies, with the consent of the patient, for purposes of submission of claims, for reimbursement or payment of dental care, predetermination of dental treatment, open and update patient files, invoice patients for dental services, and to process dental claims. Contact information is also used for communication with the patient and to send appointment reminders to patients.
* Medical information is disclosed, with consent of the patient, to other dentists, dental specialists, or health care professionals such as physicians. It is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.
* Financial information is collected for payment processing purposes. It is not shared with third parties unless permitted by law for outstanding bill collection purposes.

In the event our dental office ever sells the practice, the new dental practitioner may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale, all personal information will be safeguarded. Dentists are regulated by the College of Dental Surgeons of Alberta 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 and that of my dependent minors.

Signature of Patient or Responsible Party:_____ Date:_____