metro dental

Patient Registration Form

Information provided will be kept confidential

Last Name:	First Name:		Middle Name:
Address:			Date of Birth: dd / mm / yyyy
City:	Provice:	Postal Code:	Gender: Male / Female
Email Address:			Home Phone:
Occupation:	Employer:		Work Phone:
Family Doctor:	Doctor Phone:		Cell Phone:
Emergency Contact:	Relationship to patient:		Emergency Phone:
Whom may we thank for referring you?			Relationship to patient:
Who is responsible for this account?			Relationship to patient:
If not, how did you hear about us? Drive By / Walk-in / Internet Search / Newspaper			

Dental History

Reason for this visit:	When was your last dental visit?
Name of your last dentist:	Do you have x-rays taken within last 12 months?
How often do you brush?	How often do you floss?
Do your gums ever bleed?	Do you have loose or drifting teeth?
Do you know if you grind your teeth?	Does your jaw click, pop or hurt?
Are you satisfied with the appearance of your teeth?	
Have you had any complications or difficulty with previous dental treatment?	
How do you rate yourself as a dental patient? Calm / Slightly Nervous / Very Anxious	

Medical History

Are you currently in good health? If no, please explain		
Are you under the regular care of a physicians? If yes, please explain		
Have you ever had a serious illness or operation? If yes, please explain		
Do you currently have or ever had any of the following conditions? Please checked where applicable		
☐ Arthritis ☐ Asthma or Breathing Problems ☐ Abnormal Bleeding or Blood Disorder ☐ Diabetes ☐ Epilepsy or Seizure ☐ Heart Trouble or Stroke ☐ Heart Murmur	☐ Hepatitis ☐ High or Low Blood Pressure ☐ HIV Positive ☐ Hormonal Disorder ☐ Kidney Disease ☐ Liver Disease ☐ Psychiatric Care	☐ Rheumatic Fever ☐ Thyroid Disorder ☐ Tuberculosis ☐ Tumors or Cancer ☐ Venereal Disease ☐ Other: _____
Are you allergic to or ever had a reaction to any of the following? Please checked where applicable		
☐ Aspirin (ASA) ☐ Codeine	☐ Local Anesthetic ☐ Penicillin	☐ Sulfa Drugs ☐ Other: _____
Do you smoke? If yes, how long have you been smoking?	Have you had persistent cough for the last 24 hours?	
Women: are you pregnant? If yes, how many weeks pregnant?		
Any other physical conditions of which the doctor should be aware of?		
Are you currently taking any medications or vitamins? If yes, please list		
Signature: _____ **Date:** _____		

Financial Arrangements

Thank you for choosing Metro Dental as your dental care provider. The following is a statement of our office financial policy. We ask that you please read in full and sign before your first appointment with our office.

Insurance

□ **Option 1- Non-Assignment**
As a courtesy to our patients, we will send in all of your information to your insurance company on your behalf, to have you receive payment from them directly. We will assist you in the paperwork for your health spending account if needed. By choosing this option you assume the responsibility to pay the full amount all dental treatment services rendered on the day of treatment. We accept Debit, Visa and Mastercard.

□ **Option 2 - Assignment**
As a courtesy to you, our office will accept assignment (direct payment) from your insurance company as long as we have a valid credit card number on file. If your insurance company provides us with a breakdown you will be expected to pay your balance at the time of appointment. You can use Debit, Visa or Mastercard at this time in the office. If your insurance does not provide us with a breakdown we take 20% at the time of your appointment and will adjust the balance once we have collected the payment from your insurance company.

Card Type:_____

Credit Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Exp: __ / __

X _____
Cardholder Name

X _____
Cardholder Signature

Missed Appointments

As a courtesy to our other valued patients, **We require 48 hours notice (2 Business days) for all cancellations or changes to scheduled appointments and five (5) business days notice for appointments scheduled on Saturdays. Our office policy for short notice cancellations is a fee of $50.00 which will be applied to your account.** Please help us serve you better by keeping your scheduled appointment times, as this time is reserved especially for you.

Pre- Authorization Policies

Many insurance compaines require authorizations for specific procedures in advance. In most cases we can begin treatment without receiving an authorization, however; patients need to understand if insurance refuses to pay for treatment, you are responsible for all fees. Naturally we will provide you the full cost for treatment in advance so you know the exact cost of treatment. As per your request, we are happy to submit authorizations to your insurance company for estimated confirmation of costs.

Financing

Finanical options may be available and can be discussed for major treatment or orthodontic treatment. These options must be discussed prior to the start of treatment.

I have read the financial policy and agree with the financial policy.

X _____ X_____

Signauture of Patient or Responsible Party Date

Personal Information Consent and Financial Agreement

We are committed to protecting 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, home and/or work telephone numbers, and email 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 and/or legal guardians or persons financially responsible for patient accounts for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party benefit providers, insurance companies and government agencies.
- To send reminders to 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 patients behalf. Financial information may be collected in order to make arrangements for the payment of dental services from whoever had been written as financially responsible for the account.

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 all third-party benefit providers, insurance companies and government agencies where a claim is being submitted for reimbursement or payment of all or part of the cost of dental treatment.
- To other dentists and dental specialists, where further information and/or discussion is required.
- To other dentists and dental specialists if the patient has been referred by us to the other dentist or dental specialist for treatment.
- To other health care professionals such as physicians if the patient has been referred by us to the other health care professional for either a second opinion or treatment.
- Where we are seeking and/or providing information to the following laboratories, radiology centres, hospitals, etc.
- To include the following when necessary, such as: videos, pictures, slides, etc., for educational purposes.

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 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 interests.

I hereby certify that the dental and medical histories provided are accurate and complete to the best of my knowledge. I consent to the collection, use and disclosure of my personal information as set out above and I am aware of the office cancellation policy. I also agree that I am financially responsible for all charges, whether or not paid by insurance.

Patient's Name: _____

Patient's / Parent's / Legal Guardian's Signature: _____

Date: _____

Consent For Local Anesthetic and Injections

I, (print name) _____, herbly authorize Metro Dental's medical staff, including treating dentists and hygienists to preform a local anesthetic injection(s).

I understand, and it has been explained to me that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur they might include the loss of, or disturbed sensation of the tounge and lip on the side of the injection. If this occurs it is often temporary, and the normal sensation usually returns within several days. However, in very rare cases, the loss of sensation may extend for a longer period and may become more permanent. In addition, injecting a foreign substance into the body, such as an anesthetic agent, may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

I further understand that individual reactions to treatment cannot be predicted and that if I experience any unanticpated reactions following the injection(s), I agree to report them to the office as soon as possible.

I have been told that the success of my dental treatment depends on my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and repoting any changes of my health status to the office.

I acknowledge that no guarentees or assurances have been given by anyone as the results that may be obtained.

I have discussed all of the above with the doctor, and have all of my questions or concerns addressed.

I also agree that any images/video taken of me, excluding dental records, x-rays and patient identification photo, may be used in whole or in part for promotional purposes online or in print.

In compliance with Canadian Anti-Spam Laws, you understand that by signing this form, you give us permission to send you information such as appointment reminders, appointment confirmations, news and events.

X: _____
Patient's/ Legal Guardian's Signature

X: _____
Date

X: _____
Witness Signature

X: _____
Dentist/ Hygienist Signature