BOW TRAIL DENTAL

Patient Information

Name: _____ ☐ Male ☐ Female ☐ Other
First *Middle* *Last*

Preferred Name: _____ Email: _____

Birthdate: _____ ☐ Single ☐ Married ☐ Other
DD/MM/YYYY

Address: _____ _____ _____ _____
Apt *Street* *City* *Prov* *Postal Code*

Phone #'s: _____ _____ _____
Home Phone *Cell Phone* *Work Phone with Extension*

Employer: _____ Occupation: _____

Emergency contact: _____ _____ _____
Name *Relationship* *Phone*

How did you hear about us? ☐ Mail/Flyer ☐ Community Magazine ☐ Instagram ☐ In the Neighborhood
☐ OpenCare ☐ Google ☐ Family & Friends ☐ Other _____

Whom may we thank for referring you to our practice? _____

Payment Policy

Please select an option:

☐ **OPTION #1 - Full Payment at Time of Service:**

Full payment is due at the time of treatment and your insurance company reimburses you (if applicable).
We accept cash, Interac, VISA or Mastercard.

☐ **OPTION #2 - Direct Billing to Your Insurance:**

A credit card must be kept on file. Once we have received payment from your insurance company, we will process the balance on your credit card. You will be contacted before your credit card is charged if the balance is over $100.00.

Credit Card Number: _____ ☐ VISA ☐ MASTERCARD

Expiry: _____ CVC: _____ Print name as it appears on card: _____

I hereby assign my benefits from my claims and those of my dependents to Bow Trail Dental and authorize payment to Bow Trail Dental.

Policyholder's Signature
_____

Appointment Policy

Changing an Appointment:

- If you are unable to keep your appointment, please notify us as soon as possible so that we may accommodate another patient.
- We require at **least 2 business days** before your scheduled visit to avoid a missed appointment fee of $80.00.

Dental History

What is the reason for your appointment today? _____

_____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor
Are you currently in pain? ☐ Yes ☐ No
How frequently do you see the dentist? _____
When was your last dental visit? X-ray? _____
Do you require antibiotics before dental treatment? ☐ Yes ☐ No
Have you ever had complications with local anaesthetic (freezing)? ☐ Yes ☐ No
*If yes, please explain:*_____
Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐
No Does your jaw crack, pop, or grate when you open your mouth widely? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No
Do you grind or clench your teeth? ☐ Yes ☐ No
Do you wear a nightguard? ☐ Yes ☐ No
Have you ever had an accident, injury, or surgery involving your mouth? ☐ Yes ☐ No

Do you brush your teeth daily? ☐ Yes ☐ No
Do you floss or use recommended dental aids daily? ☐ Yes ☐ No
Are your teeth sensitive? ☐ Yes ☐ No
*If yes, please explain:*_____
Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never
Do you have bad breath or a bad taste in your mouth? ☐ Yes ☐ No
Have you ever had any abnormal bleeding associated with previous extractions? ☐ Yes ☐ No
Does food catch between your teeth? ☐ Yes ☐ No
Have you experienced problems with any previous dental work? ☐ Yes ☐ No

Is there anything you would like to change about your smile?

☐ Whiter Teeth ☐ Straighter Teeth ☐ Other
If other, please explain:

_____

_____

_____

For Children: Are there any habits such as: ☐ Thumb sucking ☐ Tonsillitis ☐ Snoring ☐ Nail biting ☐ Mouth breathing ☐ Teeth grinding ☐ Chewing foreign items

Medical History

Physician's name: _____

Phone#: _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Are you taking any prescription, over the counter or herbal medicines? ☐ Yes ☐ No
If yes, please list: _____

Have you ever had a serious illness or operation? ☐ Yes ☐ No
*If yes, please list:*_____

Do you use tobacco or cannabis in any form? ☐ Yes ☐ No
If yes, please explain: _____

Are you allergic to any of the following? Please circle.

Aspirin	Erythromycin	Sedatives
Clindamycin	Jewelry/Metals	Sulfa drugs
Codeine	Tetracycline	Latex
Penicillin	Dental Anaesthetic	Other

Please list additional drugs/materials that cause allergic reactions:

_____

Have you ever fainted, had shortness of breath or chest pains? ☐ Yes ☐ No

Do you bruise easily or have prolonged bleeding? ☐ Yes ☐ No

Are you taking oral contraceptives? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No Week # _____
Are you nursing? ☐ Yes ☐ No

Please circle any of the following conditions that you currently experience or have in the past.

Abnormal Bleeding	Congenital Heart Defect	Heart Surgery/Pacemaker	Mental/Nervous Disorder
AIDS/HIV Positive	Congenital Heart Lesions	Heart Rhythm Disorder	Organ Transplant/Implant
Anemia	Diabetes	Hepatitis A/ B/ C	Psychiatric Disorders
Anorexia	Drug or Alcohol Dependence	Herpes	Radiation/ Chemotherapy
Arthritis/ Rheumatism	Emphysema	Hodgkin's Disease	Rheumatic/ Scarlett Fever
Artificial Joints or Valves	Epilepsy	Hyper/Hypoglycemia	Sexually Transmitted Infection
Asthma	Gastrointestinal Disease	Hypertension	Sinus Trouble
Blood Disorders	Glandular Disease	Jaundice	Steroid Therapy
Bulimia	Glaucoma	Kidney Disease	Stroke
Cancer	Headaches	Leukemia	Thyroid Disease
Cardiovascular Disease	Head or Neck Injury	Low Blood Pressure	Tuberculosis
Colitis	Heart Attack	Lung Disease	Ulcers

Insurance Policy

- Your insurance is a contract between you, your employer, and your insurance company.
- We ask that you be aware of your coverage, including maximums and limitations, and how much you have used.
- Any portion of fees not covered by your insurance plan or that exceed your insurance limit is your responsibility.
- Families that have dual insurance coverage may still have a portion of the fees not covered by either of the plans.
- If your insurance company does not give us an Explanation of Benefits immediately after your treatment, we will collect an estimated amount based on the most up-to-date information we have from your previous claims.
- 100% coverage does not always translate to 100% paid. The agreement between you and your insurance company may cover you at a reduced fee guide.

We are here to assist you with any questions you may have regarding your coverage. Please feel free to bring in your insurance policy booklet.

Dental Photography

I hereby authorize Bow Trail Dental and its employees to take photographs, and/or videos of the head and neck areas, including the profile, face, teeth, smile and intra-oral features, before treatment, during treatment for the purposes listed below. These images may be used in advertisements and online media. I understand that my/child's images may be edited, copied, exhibited, published or distributed and waive the right to inspect of approve the finished product where in my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording.

I consent to allow the photographs/videos to be used for the following purposes:

- Dental Records and Treatment Planning.
- Continuing Care Purposes.
- Dental Research (approved by ethics committee).
- Dental Education (including lectures, seminars, demonstrations, professional publications).
- Patient Education.
- Marketing Material (including websites, social media posts and printed materials).

☐ Yes, you have my consent to dental photography for the reasons listed above.
☐ Yes you have my consent to dental photography, but please do not use the photos for marketing purposes.

Authorization

I confirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

I authorize Dr. Sean Wong and his employees to perform the dental services agreed to be necessary.

I agree to the Payment Policy and Appointment Policy as outlined above.

I consent to Dental Photography as per the section above.

I consent to electronic (text and email messages) with Bow Trail Dental and may opt out at any time.

I am the: ☐ patient ☐ parent / legal guardian. *For parent / legal guardian please indicate your date of birth:* _____
DD/MM/YYYY

_____	_____	_____
Patient Name	Patient Signature	Legal Guardian Signature

Personal Consent Form

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 contact information from our patients (names, addresses, phone numbers, email address, employer's names, and work phone numbers) for the following purposes:

- To open & update patient files.
- To process credit card payments and 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 and
- To send patients informational material about our dental office.

Contact information is disclosed to third party health benefit providers and insurance companies when the patient has submitted a claim for reimbursement, or payment (of all or part of) the cost of dental treatment, or the patient has asked us to submit a claim on their behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect medical information from our patients about their health history, their family health history, physical condition, and dental treatments. Patients' medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' medical information is sometimes disclosed to the following:

- Third party health benefit providers and insurance companies when 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.
- Other dentists and dental specialists when we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- Other dentists and specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- Other dentists and dental specialists when those dentists have asked us, with the consent of the patient, to provide a second opinion.
- 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 were to sell 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 & College, who 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.

Printed Name: _____ Signature: _____ Date: _____

Patient OR Parent/Legal Guardian *Patient OR Parent/Legal Guardian* *DD/ MM/ YYY*