Medical History Form

Patient Name: ______________________________ Sex: ______ Date of Birth (DD/MM/YY): ____/_____/____

Home Number: (_______) __________-___________ Work Number: (_______) __________-_____________

Mobile Number: (_______) __________-___________ Email Address: ____________________________

Street Address: _______________________________ Apt#/ Suite#: __________

Province: _____________ City: __________________________ Postal Code:________________

If patient is a minor, who is legally responsible? Name: __________________________D.O.B.:______________

Relationship:________________________________ Phone Number: (______)____________-______________

Address:____

Alberta Health Care Number:____

How did you hear about us? □ Referral by Dentist □ Google or other search engine □ Facebook □ Flyer
□ Signage □ Phone Book □ Word of Mouth □ Family member or friend:__________________________
□ Movie Theatre □ Other:_____________________________

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the surgery and/or sedation you will receive. Thank you for answering the following questions.

Are you taking any medications, pills, or drugs? □ Yes □ No If yes, please list:

____

Do you have any known allergies? ____

Do you use any herbal supplements? □ Yes □ No If yes, please list:____________________________________

Do you drink alcohol? □ Yes □ No If yes, how many drinks per week?:__________________________________

Do you use any controlled substances? □ Yes □ No If yes, please list:_________________________________

Do you smoke regularly? □ Yes □ No If yes, how much per day?_______________________________________

Are you being treated for any medical condition at the present time or have you been treated within the past year?

□ Yes □ No If yes, please explain:

____

Has there been any change in your general health in the past year? □ Yes □ No If yes, please explain:

____

Do you have a bleeding problem or bleeding disorder? □ Yes □ No

Are there any diseases or medical problems that run in your family? (Diabetes, cancer or heart disease) □ Yes □ No

If yes, please explain:____

Have you been diagnosed with Sleep Apnea? □ Yes □ No   If so, do you use a CPAP machine? □ Yes □ No

Do you get chest pain or shortness of breath when you climb up 2 flights of stairs or walk 4 blocks? □ Yes □ No

Have you or a family member ever experienced an adverse reaction to sedation medications or general anesthesia?

□ Yes □ No If yes, please explain.____

____

Do you have, or have you had, any of the following? Check (√) yes if applicable:

□ Acrylic Allergy	□ Diabetes	□ Irregular Heartbeat
□ AIDS/HIV Positive	□ Drug Addiction	□ Kidney Problems
□ Amoxicillin Allergy	□ Emphysema	□ Latex Allergy
□ Anaphylaxis	□ Epilepsy or Seizures	□ Leukemia
□ Anemia	□ Excessive Bleeding	□ Liver Disease
□ Angina	□ Excessive Thirst	□ Local Anesthetics Allergy
□ Arthritis/Gout	□ Fainting Spells/ Dizziness	□ Low Blood Pressure
□ Artificial Heart Valve	□ Frequent Headaches	□ Metal Allergy
□ Artificial Joint	□ Glaucoma	□ Pain in Jaw Joints
□Aspirin Allergy	□ Hay Fever	□ Parathyroid Disease
□ Asthma	□ Heart Attack/Failure	□ Penicillin Allergy
□ Blood Disease	□ Heart Disease	□ Radiation Treatments
□ Blood Transfusion	□ Heart Pace Maker	□ Renal Dialysis
□ Breathing Problem	□ Heart Trouble	□ Rheumatism
□ Bruise Easily	□ Hemophilia	□ Sinus Trouble
□ Cancer	□ Hepatitis A	□ Stroke
□ Chemotherapy	□ Hepatitis B	□ Taking Birth Control
□ Chest Pains	□ Hepatitis C	□ Thyroid Disease
□ Clindamycin Allergy	□ Herpes	□ Tuberculosis
□ Codeine Allergy	□ High Blood Pressure	□ Tumors or Growths
□ Cold Sores/Fever Blisters	□ Hives or Rash	□ Ulcers
□ Cortisone Medication Allergy	□ Hypoglycemia	□ Yellow Jaundice

Women: Are you pregnant? □ No □ Yes   Due Date: ___/____/____

Have you ever had any serious allergy, illness or accident not listed above? □ Yes □ No If yes, please explain:

____

Please list previous surgeries: ____

____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information may be dangerous to my (or patient's) health. It is my responsibility to inform Timberlea Services Centre of any changes in medical status.

Signature of Patient, Parent or Guardian ______________________   *Date:* ____/____/_____

Financial Policies & Guidelines

Patient Name:___________________________________ **Date:**___________________________

1. Any fees for consultations or x-rays will be collected at the time of the initial appointment, and we will help you with submitting for reimbursement from your dental insurance.

2. Should you require dental surgery, upon booking, we require a $500 deposit to reserve your time with the Medical Anesthesiologist. This will be credited towards your anesthesia fees on the day of surgery.

3. In order for us to direct bill your dental insurance, we require the pre-authorization back in office 7 days prior to your surgery date. We will then request payment of the balance not covered by your dental insurance on the day of surgery (NOTE: If we do not receive payment from the insurance company within 30 days after surgery, the amount will be applied directly to your credit card). Overdue balances will be sent to collections upon our discretion.

4. If written pre-authorization or insurance information has not arrived 7 days prior to the surgery date, we request full payment on the day of surgery and we will submit, on your behalf, a form directly to your insurance carrier for any reimbursement.

5. Your sedation will be administered and monitored at Timberlea Services Centre and *this service is not covered under Alberta Health Care for dental procedures at our facility.* The anesthesia fees and facility fees for your sedation services will be collected on the day of surgery in full ($500 booking deposit will be credited towards these fees). We will submit, on your behalf, a form directly to your insurance carrier for any reimbursement.

6. If you have insurance coverage through 2 dental insurance companies, we require a $500.00 deposit towards dental services on the day of surgery. Adjustments will be made as required, once both dental plans pay their allowable amounts. Please note Timberlea Services Centre only accepts 2 dental insurances.

7. Payments can be made with Debit, MasterCard, Visa, AMEX or Cash. We also offer third party financing through MEDICARD.

8. Timberlea Services Centre has a 2 business day cancellation policy. We require 2 business days notice for cancellation or rescheduling of your appointment or a $500 cancellation fee will be applied to the credit card on file.

9. Due to the nature of our practice, we do our best to accurately estimate treatment fees. However, unforeseen circumstances may arise where an adjustment to treatment cost may be needed and therefore we do require a valid credit card be left on file. Any differences in your treatment plan will automatically be applied to the credit card on file.

I (print name) ____ *have read and completely understand Timberlea Services Centre's Financial Policies and Guidelines for booking Dental Surgery and agree to adhere to them for myself or my dependents. I will notify Timberlea Services Centre if there are any changes to my credit card information.*

NOTE: *We do not phone patients prior to applying the balance to the credit card*

Credit card type: ____

Name on credit card: ____

Credit card number: ____

Expiry date: ____

Signature: ______________________________________ ***Date:*** ______________________________

Dental Insurance Coverage

See our *Financial Policies and Guidelines form* for information about our direct billing policy

Primary Dental Insurance:

Cardholder's name: ______________________________
Cardholder's date of birth: ________________________
(DD/MM/YYYY)
Insurance/company name:_________________________
Group Number: _________________________________
ID/Certificate Number: ___________________________

Secondary Dental Insurance

Cardholder's name: ______________________________
Cardholder's date of birth: ________________________
(DD/MM/YYYY)
Insurance/company name:_________________________
Group Number: _________________________________
ID/Certificate Number: ___________________________

Third Dental Insurance Policy:

Unfortunately our office and computer system is not set up to deal with 3 insurance companies. We will submit your dental claims to your first two policies, but if there is still a balance owing you will be required to pay this amount. If you wish to utilize your third insurance company, we will supply you with the necessary forms. It will be up to you to fill them out and submit them for any possible reimbursement.

Personal Information 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 information from our patients such as names, home addresses, work addresses, home telephone numbers, and work telephone numbers (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 from third-party health benefit providers and insurance companies on the patients behalf

Contact information is disclosed to third party health benefit providers' insurance companies where the patient has asked the office 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 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 and medical treatment (anaesthesia or sedation).

Patients' Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has requested the office submit a claim for reimbursement of all or part of the cost of dental/medical treatment on their behalf
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented (verbal or written) to use 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 healthcare professional such as physicians if the patient, with their consent, has been referred by us to other healthcare professionals for either a second opinion or treatment

As a Dental Surgical Facility/Non-Hospital Surgical Facility we are regulated by the Alberta Dental Association and College and the College of Physicians and 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.

__________________	______________________	__________________________	____________________
Date	Print Name- Patient (Guardian)	Signature	Witness