MONARCH LANDING DENTAL

PH: 403-300-1200 EMAIL: info@monarchlandingdental.ca ADDR: #110, 3003, 37th St SW Calgary AB T3E 3B5

Patient's Name: _____
First Name Middle Initial Last Name

Name of Parent/Guardian: _____ (If patient is under 18)

Address: _____

City: _____ Province: _____ Postal Code: _____

Email Address: _____

(Please print your e-mail address clearly in CAPITAL LETTERS) *required for pre-authorizations

Home Phone: _____ Business: _____ Cell: _____

Date of Birth: /____/____/____ Gender: M ☐ F ☐ - If you identify otherwise, we would like to respect your preferences. Please indicate your preferred pronouns here: _____
Day Month Year

INSURANCE INFORMATION

Dental insurance: Y ☐ N ☐ Full name of policy holder: _____

Insurance Company: _____

Policy Holder's Employer: _____
*required for direct insurance billing

Policy/Group #: _____ I.D./Certificate #: _____

Policy Holder's Date of Birth: /____/____/____
Day Month Year

Patient's relation to policy holder: Self ☐ Spouse ☐ Common-Law ☐ Child ☐ Full-Time Student ☐ Other ☐

Are you covered under any other insurance policies? Y ☐ N ☐ If yes, please provide the following information:

Full name of policy holder: _____

Insurance Company: _____

Policy Holder's Employer: _____
*required for direct insurance billing

Policy/Group #: _____ I.D./Certificate #: _____

Policy Holder's Date of Birth: /____/____/____
Day Month Year

Patient's relation to policy holder: Self ☐ Spouse ☐ Common-Law ☐ Child ☐ Full-Time Student ☐ Other ☐

CONSENT

This is to certify that I, undersigned, consent to the performing of the dental procedures and/or oral surgery that are agreed to be necessary/advisable. I understand that I am responsible for payment on the day of service for any fees not covered by my insurance, unless prior arrangements have been made. I understand that 24 hour notice is needed to re-arrange or cancel my reserved appointment time or a cancellation fee may apply. I understand that 5% monthly interest is charged on all unpaid accounts, delinquent for 90 days or more.

I acknowledge that I have read and accept the conditions noted above.

Signature of Patient: _____ *Date:* _____
(or Legal Guardian if patient is a minor child)

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Monarch Landing Dental

1. Do you have dental phobias and/or are you nervous during dental treatment? Y☐ N☐

Please rate your anxiety level

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Little to no anxiety — Some anxiety (manageable) — Extreme anxiety (sedation required)

2. Have you ever been told that you require pre-medication prior to dental procedures? Y☐ N☐

3. Are you currently taking any prescription medications, non-prescription drugs or herbal supplements of any kind? Y☐ N☐

If yes, please list them: _____

_____

_____

4. Have you ever been hospitalized for any illnesses or operations? Y☐ N☐ If yes, please list them: _____

_____

_____

5. Are you currently having any therapies that could affect your immune system? (i.e. radiotherapy, chemotherapy) Y☐ N☐

If yes, please list them: _____

_____

6. Do you smoke or chew tobacco products? Y☐ N☐

If yes, how many cigarettes do you smoke per day: _____

7. Do you now or have you ever had the following:

Heart Disease (heart attack/stroke)	☐ Y	☐ N	Rheumatic Fever	☐ Y	☐ N
Pacemaker	☐ Y	☐ N	Osteoporosis	☐ Y	☐ N
Heart Murmur	☐ Y	☐ N	Liver Disease	☐ Y	☐ N
Mitral Valve Prolapse	☐ Y	☐ N	Sinus Trouble	☐ Y	☐ N
Heart Valve Replacement or Repair	☐ Y	☐ N	Glandular Disorders	☐ Y	☐ N
Epilepsy	☐ Y	☐ N	Low Blood Pressure	☐ Y	☐ N
Hepatitis A	☐ Y	☐ N	High Blood Pressure	☐ Y	☐ N
Hepatitis B	☐ Y	☐ N	Lupus	☐ Y	☐ N
Hepatitis C	☐ Y	☐ N	Herpes	☐ Y	☐ N
Anemia	☐ Y	☐ N	Asthma	☐ Y	☐ N
Fainting or Dizzy Spells	☐ Y	☐ N	Shortness of Breath	☐ Y	☐ N
HIV or AIDS	☐ Y	☐ N	Emphysema	☐ Y	☐ N
Type 1 Diabetes	☐ Y	☐ N	Lung Disease	☐ Y	☐ N
Type 2 Diabetes	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Cancer	☐ Y	☐ N	Chest pain/Angina	☐ Y	☐ N
Organ Transplant	☐ Y	☐ N	Alcohol Dependency	☐ Y	☐ N
Prosthetic or Artificial Joint	☐ Y	☐ N	Drug Dependency	☐ Y	☐ N

8. Do you have any medical conditions or diseases that are not listed above? Y☐ N☐ If yes, please list them: _____

_____

_____

9. Are you now or have you ever been allergic to any of the following:

Aspirin	☐ Y	☐ N	Codeine	☐ Y	☐ N
Sulpha Drugs	☐ Y	☐ N	Penicillin	☐ Y	☐ N
Ibuprofen	☐ Y	☐ N	Latex	☐ Y	☐ N
Local Anesthetics	☐ Y	☐ N			

10. Women Only: Are you breastfeeding, pregnant, or think you might be? ☐ Y ☐ N

11. Name of your medical doctor: _____

12. Doctor's office phone number: _____

Monarch Landing Dental

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, home telephone numbers, work telephone numbers, and e-mail 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 for dental services, to process credit card payments, or 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 and/or treatment.

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.

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 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 patient's behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us 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 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.
- To secondary uses of data for the purposes of research and development (R&D), education and quality assurance purposes, where all patient information would be de-identified and anonymized prior to any disclosure of information.

If we are ever considering selling all or part of the 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 and College 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***	***Signature***

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How did you hear about our office? _____

I, _____, am aware that the Monarch Landing Dental requires a minimum of 24 hours notice if I need to cancel or reschedule an appointment. I am also aware that if I do not provide a minimum of 24 hours notice my account will be charged. Missed appointment fees are billed as follows:

- 1ST missed appointment - $50.00
- 2ND missed appointment - $75.00
- 3RD missed appointment - $100.00

I, _____, understand that it is my responsibility to keep track of and attend my appointments on time. I realize that the two day confirmation call I receive from the Monarch Landing Dental is a ***courtesy*** call and, if for any reason I do not receive a call, I am still responsible for any missed appointment fees incurred. Furthermore, I realize that if I am more than 15 minutes late for a scheduled appointment this counts as a missed appointment and the above fees will apply.

I, _____, am aware that the Monarch Landing Dental is not responsible for denied dental claims. If for any reason my dental insurance does not cover 100% of my dental expenses, I understand that any remaining balance is my responsibility.
I am aware that the dental office does not have access to my specific dental insurance information. I understand that when the staff or dentists of the clinic suggest services, they are suggesting what is dentally necessary. By suggesting services they are in no way implying that my dental insurance will cover these services.
I understand that it is my responsibility to be sure that my dental coverage is in effect on the date of services rendered, and any plan maximums have not been exceeded.
If I require specific information about my policy I understand that it is best to contact my insurance carrier directly. Monarch Landing Dental staff is not able to provide any guarantees regarding individual coverage.

I, _____, understand that any and all unpaid accounts delinquent for 90 days or more are sent to a third party for collection. I acknowledge that said third party will report my delinquent accounts to any and all credit reporting bureaus which will adversely affect my credit rating.

I acknowledge that I have read and accept the conditions noted above.

Signature of **Patient** _____
(or **Guardian** if minor child)

Date _____/_____/_____
Day **Month** **Year**