Confidential Patient Record

Patient: Mr. / Mrs. / Miss_____
Surname First Middle

Date of Birth: _____ Emergency Contact Name: _____ Phone #:_____
Day Month Year

Address:_____ Marital Status: ☐ Married ☐ Single
City/Prov: _____ Postal Code: _____ **Email:** _____
Home #: _____ Work #: _____ Cell #: _____
Occupation: _____ Employer: _____
How did you hear about us? Postcard Internet Search Walk By (big sign) Newsletter
(please circle) Website Friend/Family Referral (name) _____
Other (please specify) _____

Do you have Dental Insurance Coverage? ☐ Yes ☐ No If yes, please provide us with benefits card for direct billing

Medical History

1. Are you currently in good health? ☐ Yes ☐ No
   If no, please explain _____
2. Are you currently taking any medications or vitamins (prescription, over-the-counter, recreational)? ☐ Yes ☐ No
   If yes, please list_____
3. Do you currently smoke? ☐ Yes ☐ No
4. Are you allergic to or ever had a reaction to any of the following: **(please circle)**
   Penicillin Local Anesthetic (Freezing) Sulfa Drugs Erythromycin
   Codeine Aspirin (ASA) Latex Other _____
5. Are you under the regular care of a physician ☐ Yes ☐ No
   If yes, Please explain _____
6. Do you bleed more or longer than normal after a cut, bruise, surgery or previous tooth removal? ☐Yes ☐No
7. Have you ever had a serious illness or operation? ☐ Yes ☐ No
8. Do you currently have or ever had any of the following conditions? **(please circle)**

Heart Trouble or stroke	Heart Murmur	Thyroid Disorder	Rheumatic Fever
Breathing Problems	Frequent Diarrhea	HIV + / AIDS	Tumors or Cancer
High / Low Blood pressure	Hepatitis ☐ A ☐ B ☐ C	Artificial Joints	Liver /Kidney Disease
Mental Illness	Diabetes (Type I/II)	Tuberculosis	Epilepsy or Seizure
Blood Disorders	Asthma	Hormonal Disorder	Other: _____

   Women: Are you Pregnant? ☐ Yes ☐ No If yes, which trimester? _____
9. Is there anything else we should know about your health? ☐ Yes ☐ No If so, please explain_____

Dental History

1. What dental condition(s) concern you at present? _____
2. When was your last dental check-up and cleaning? _____
3. Were X-rays taken at your last dental visit? ☐ Yes ☐ No
4. When was the last time you changed Dental Offices _____
5. Have you noticed any signs of the following? **(please circle)**
   Bleeding gums Swelling of Gums Gum Ache Receding Gums Loose Teeth Drifting of Teeth
6. Do you have any clicking, popping or pain in your jaw joint? ☐ Yes ☐ No
7. Are you aware of clenching or grinding your teeth? ☐Yes ☐ No
8. Do you have any missing teeth that you feel should be replaced? ☐ Yes ☐ No
9. Would you like to improve the appearance of your teeth? ☐ Yes ☐ No
10. Do you floss your teeth? ☐ Yes ☐ No
11. Have you had any complications or difficulty with previous dental treatment? ☐ Yes ☐ No
12. How do you rate yourself as a dental patient? ☐ Calm ☐ Lightly Nervous ☐ Very Anxious

I hereby certify that the Medical and Dental Histories provided are accurate and complete to the best of my knowledge. I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic or any drugs as indicated and I will assume responsibility for fees associated with those procedures.

Date_____ Signature _____

Office Policies

Copperstone Dental complies with the Alberta Personal Information Act (PIPA) and the Health Professions Act in regards to the management, collection, destruction, use and disclosure of our patient's personal dental/medical history information.

Cancellation Policy

Due to a continuous high demand in prime appointment times, we require a **minimum of 2 business days** advance notice should you require to reschedule your appointment. This is valuable time that the Doctor and staff have reserved specifically for you. In the case that insufficient notice is given or you fail to attend your appointment on multiple occasions, we will not be able to schedule and reserve future appointment times for you.

Direct Billing

Due to the Canadian Personal Privacy Act, we are unable to access any sufficient information from your insurance company regarding your dental plan. It is **your responsibility** to know the details involved in your plan such as annual maximums, frequencies, and any other limitations. We extend the **courtesy to bill your insurance** directly, however to avoid any patient portion discrepancies, please be fully aware of the particulars of your plan so you can utilize your benefits to their maximum. **Copperstone Dental** can also provide estimates when requested so you may budget your finances accordingly.

Copperstone Dental is pleased to offer you the following payment options. Please **CIRCLE** which option you would like to participate in.

Option A

Payment is due in full the day of treatment is rendered. We accept Cash, Visa, Debit, MasterCard, and American Express. **Copperstone Dental** will process your payment on the date treatment is rendered. Our treatment coordinator will assist you in submitting the necessary documents to your insurance carrier and the insurance cheque will be sent directly to you, the patient.

Option B

You will be required to leave your credit card number on file and we will direct bill your insurance company. Any outstanding amounts will be applied to your credit card on file once your insurance company has paid us their portion.

If we receive an explanation of covered costs from your insurance company at the time of your visit, you will be required to pay the outstanding balance before you leave.

Please sign below acknowledging that you have read and understand the office polices at **Copperstone Dental**.

Date: _____ Signature: _____

For **Option B only:**

I, _____ have chosen **Option Two,** and herby authorize any balances outstanding which is not covered by my dental insurance to be automatically applied to:

Credit Card **(circle one):** Visa MasterCard American Express

Card Number: _____-_____-_____-_____ Expiry Date :_____(mm/yyyy)

Name **(as it appears on card)**:_____

Signature of Cardholder:_____

Receipts will be emailed to the following address: Email: _____ (if requested)