



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

- Are you currently in good health? Yes No
If no, please explain _____
- Are you currently taking any medications or vitamins (prescription, over-the-counter, recreational)? Yes No
If yes, please list _____
- Do you currently smoke? Yes No
- 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 _____
- Are you under the regular care of a physician Yes No
If yes, Please explain _____
- Do you bleed more or longer than normal after a cut, bruise, surgery or previous tooth removal? Yes No
- Have you ever had a serious illness or operation? Yes No
- 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? _____
- Is there anything else we should know about your health? Yes No If so, please explain _____

Dental History

- What dental condition(s) concern you at present? _____
- When was your last dental check-up and cleaning? _____
- Were X-rays taken at your last dental visit? Yes No
- When was the last time you changed Dental Offices? _____
- Have you noticed any signs of the following? **(please circle)**
Bleeding gums Swelling of Gums Gum Ache Receding Gums Loose Teeth Drifting of Teeth
- Do you have any clicking, popping or pain in your jaw joint? Yes No
- Are you aware of clenching or grinding your teeth? Yes No
- Do you have any missing teeth that you feel should be replaced? Yes No
- Would you like to improve the appearance of your teeth? Yes No
- Do you floss your teeth? Yes No
- Have you had any complications or difficulty with previous dental treatment? Yes No
- 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.

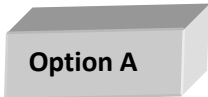
Cancellation Policy

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

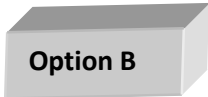
Due to the Canadian Personal Privacy Act, we are unable to access any sufficient information from your insurance company regarding your dental plan. It is **your responsibility** to know the details involved in your plan such as annual maximums, frequencies, and any other limitations. We extend the **courtesy 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 policies at **Copperstone Dental**.

Date: _____

Signature: _____

For Option B only:

I, _____ have chosen **Option Two**, and hereby 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:
(if requested)**

Email: _____