WELCOME TO OUR DENTAL OFFICE

McKenzie Towne Family Dental
Family, Cosmetic & General Dentistry

The information that is requested on this Questionnaire, Dental History and Medical History is essential to providing you with the safest and highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. PLEASE PRINT CLEARLY.

REGISTRATION INFORMATION

❑ Adult ❑ Child LAST Name:	FIRST:	MIDDLE:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: (dd/mm/yy) / /	Age:	Sex: ❑ M ❑ F

Street address:	Postal Code:	City:
Home Phone #: ( )	Cell #: ( )	Work #: ( )
Occupation:	Employer:	E-mail:

❑ Would you prefer to be reminded of your future appointments using e-mail address? (Highly recommended)

Who can we thank for your referral to our office? Name of person:

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Internet/Website ❑ Other

Other family members seen here:

Emergency Contact:	Relationship to patient:	Phone #: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance Company Name:

Subscriber's Name:	Birth date: (dd/mm/yy) / /	Policy/Plan #:	ID/Certificate #:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Secondary Insurance Company Name:

Subscriber's Name:	Birth date: (dd/mm/yy) / /	Policy/Plan #:	ID/Certificate #:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

MEDICAL HISTORY

Name of Physician:	Phone#: ( )

Please ✓ YES or NO to each question, if YES explain. If unsure of a question, please consult with dental professional

1. Are you currently being treated for any medical condition at present or within the past 2 years?	❑ Yes	❑ No
2. Have you been hospitalized in the past two years?	❑ Yes	❑ No
3. When was your last visit to a Physician?		
4. Have you recently, or are you presently, taking any prescription or non-prescription drugs including herbal remedies?	❑ Yes	❑ No

1.	2.	3.
4.	5.	6.

5. Have you ever reacted adversely to any medications or injections? (please circle) e.g. Penicillin, or other antibiotics, aspirin, codeine, local anesthetic (freezing),, or any other medicine:	❑ Yes	❑ No
6. Had you ever been advised against taking any specific type of medication?	❑ Yes	❑ No
7. Do you have any of the following? Asthma, Hay fever, food allergies, metal or latex allergies, skin rashes, hives, or any other allergic conditions?	❑ Yes	❑ No
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction?	❑ Yes	❑ No
9. Is there a family history of diabetes, cancer or heart disease?	❑ Yes	❑ No
10. Do you bleed excessively from a cut or injury, or bruise easily?	❑ Yes	❑ No
11. Have you tested HIV positive?	❑ Yes	❑ No
12. Do you have frequent severe headaches, earaches, ear/throat infections?	❑ Yes	❑ No
13. Have you ever had any injury or surgery to your face or jaws?	❑ Yes	❑ No
14. Do you have hearing difficulties?	❑ Yes	❑ No
15. Do you smoke or use any other forms of tobacco?	❑ Yes	❑ No
Are you wearing a transdermal nicotine patch?	❑ Yes	❑ No
16. Are you regularly using alcohol and/or drug s?	❑ Yes	❑ No

17. **INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:**

A.I.D.S	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Lupus	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Head/neck injuries	❑ Yes	❑ No	Malignant hypothermia	❑ Yes	❑ No
Angina pectoris	❑ Yes	❑ No	Heart disease or attack	❑ Yes	❑ No	Mental/nervous disorder	❑ Yes	❑ No
Arthritis/rheumatism	❑ Yes	❑ No	Heart murmur	❑ Yes	❑ No	Mitral valve prolapse	❑ Yes	❑ No
Artificial heart valve	❑ Yes	❑ No	Heart pacemaker	❑ Yes	❑ No	Organ transplant/medical implant	❑ Yes	❑ No
Artificial joints (hip/knee)	❑ Yes	❑ No	Heart rhythm disorder	❑ Yes	❑ No	Psychiatric treatment	❑ Yes	❑ No
Blood disorders	❑ Yes	❑ No	Heart surgery	❑ Yes	❑ No	Radiation treatment/chemotherapy	❑ Yes	❑ No
Bronchitis	❑ Yes	❑ No	Hepatitis A B C ___	❑ Yes	❑ No	Scarlet fever/rheumatic fever	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Sickle cell disease	❑ Yes	❑ No
Circulation problems	❑ Yes	❑ No	High/low blood pressure	❑ Yes	❑ No	Sinus trouble	❑ Yes	❑ No
Congenital heart lesions	❑ Yes	❑ No	Hodgkin's disease	❑ Yes	❑ No	Stomach/ intestinal problems/ulcers	❑ Yes	❑ No
Cortisone/steroids	❑ Yes	❑ No	Hyper (hypo) Glycaemia	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Crohn's disease	❑ Yes	❑ No	Hypertension	❑ Yes	❑ No	Thyroid disease	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Inflammatory bowel disease	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Jaundice	❑ Yes	❑ No	Venereal disease	❑ Yes	❑ No
Epilepsy or seizures	❑ Yes	❑ No	Kidney disease	❑ Yes	❑ No			
Fainting or dizzy spells	❑ Yes	❑ No	Liver disease	❑ Yes	❑ No			
Glandular disorders	❑ Yes	❑ No	Lung disease	❑ Yes	❑ No			

18. Has the **CHILD PATIENT** recently			Measles	❑ Yes	❑ No			
Had any of the following:			Mumps	❑ Yes	❑ No	Strep throat	❑ Yes	❑ No
(Indicate approximate date)			Chickenpox	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No

19. Do you currently have, or have you had in the past, any disease, condition or problem not listed above?	❑ Yes	❑ No
20. Is there anything else about your health we should be made aware of?	❑ Yes	❑ No
21. **Women only:** are you pregnant or suspect you may be? Expected delivery date?	❑ Yes	❑ No
Are you breastfeeding?	❑ Yes	❑ No
Are you taking any birth control pills?	❑ Yes	❑ No
Women over 50: are you aware of your bone mineral density?	❑ Yes	❑ No

DENTAL HISTORY

Please ✓ YES or NO to each question, if YES explain. If unsure of a question, please consult with dental professional

Is there a dental problem you would like treated immediately?	❑ Yes	❑ No

Date of your last dental visit? Last dental cleaning? Last X-rays?

1. Have you been seeing a dentist regularly?	❑ Yes	❑ No
2. Have you ever had any of the following?		
Periodontal treatment? (treatment of the gums)	❑ Yes	❑ No
Orthodontic treatment? (Braces to straighten or realign teeth)	❑ Yes	❑ No

A Bite plate or any other appliance? (e.g. Month Guard, Night Guard)	❑ Yes	❑ No
Your bite adjusted or teeth ground?	❑ Yes	❑ No
Oral surgery? (Surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)	❑ Yes	❑ No
If you answered yes to the last question, who performed the surgery? When?		
Are you being followed up by a dental specialist?	❑ Yes	❑ No
3. Are there any abnormal or sore spots in your mouth?	❑ Yes	❑ No
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums?	❑ Yes	❑ No
5. Have you noticed any loose teeth, or teeth that have shifted?	❑ Yes	❑ No
6. Does food catch between your teeth?	❑ Yes	❑ No
7. Are any of your teeth sensitive to heat, cold, sweets or pressure?	❑ Yes	❑ No
8. **Have you been advised to take antibiotics before a dental appointment?**	❑ Yes	❑ No
9. Do you use dental floss, proxabrush, or stimudents? How often?	❑ Yes	❑ No
10. How often do you brush your teeth? Do you feel that you have bad breath?	❑ Yes	❑ No
11. Have you ever experienced any of the following jaw problems:		
Popping/clicking in your jaw joints?	❑ Yes	❑ No
Pain in your jaw joints, around your ear, or the side of your face?	❑ Yes	❑ No
Difficulty in opening or closing?	❑ Yes	❑ No
Pain or difficulty when chewing?	❑ Yes	❑ No
12. Do you have any of the following habits?		
Clenching or grinding your teeth while awake or asleep?	❑ Yes	❑ No
Biting your cheeks or lips?	❑ Yes	❑ No
Mouth breathing while awake or asleep?	❑ Yes	❑ No
Placing foreign objects in your mouth (pencils, pipes, pins, fingernails)?	❑ Yes	❑ No
13. Do you have any concerns about having dental treatment?	❑ Yes	❑ No
14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or do you have any questions or concerns?	❑ Yes	❑ No
15. Are you unhappy with the appearance of your teeth?	❑ Yes	❑ No
And, what would you like to see changed? (e.g. Colour, Shape, Alignment, Bite)		
16. Do you feel your dental health influences your overall health?	❑ Yes	❑ No
17. On a scale of 1 to 10, 10 being the highest, how important is it for you to keep your natural teeth?		

GENERAL RELEASE (please sign after completing medical questionnaire.)

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and received answers to any questions regarding my medical - dental history. Should there be any change in either my health status or any other information I have provided I will advise this dental office. I authorized the dental provider to perform diagnostic procedures as needed to determine necessary treatment.

X

(Signature of patient / parent / guardian) *(Name of patient / parent / guardian)*

Reviewed by: Date:

Dental Insurance & Financial Agreement

McKenzie Towne Family Dental
Family, Cosmetic & General Dentistry

We offer our new and existing patients flexibility and accuracy in paying for dental treatment with the following options. Please take a minute to review them, and decide which option BEST works for you.

OPTION 1 - NON-ASSIGNMENT

This is the most popular option and by far the easiest! You will be in control of your insurance benefits, **by paying in full for treatment at each appointment, and being reimbursed directly by your insurance company**. This allows you to keep personal records of all dental transactions, insurance reimbursements, and to track how close you are to using your yearly maximum of benefits. You never have to worry about having outstanding account balances with us, and you will not have to come in to collect monies that we may owe to you due to any overpayment at your last visit. Insurance companies reimburse patients within 1-4 business days after receiving the dental claim! We can send electronic or manual claims for you at each appointment and assist you in any way we can in claim submissions.

I agree with the policies outlined in Option 1, and will sign below.

Signature of Patient or Responsible Party:_____ Date:_____
Print Patient Name(s) of all family members this applies to: _____

OPTION 2 - ASSIGNMENT with VIP Express Checkout Program

Our VIP Express Checkout Program authorizes McKenzie Towne Family Dental to Accept Assignment (Payment) of Benefits from your Insurance Carrier. It does not allow your insurance company to release any other information to us, due to the Health Privacy Act. We want to make you aware that we may experience some difficulty in communicating with your insurance company, and ask for your cooperation, understanding, and patience. Dental Providers usually receive insurance payments 2-3 weeks after date of service.

Basically, we will direct bill your insurance company, receive that payment, and you will be responsible to pay any remaining balance afterwards. All accounts must balance zero within 30 days after insurance claim is paid to our office, therefore we require a credit card to be left on file in order to set your account balance to zero.

I agree with the policies outlined in Option 2, and will sign below authorizing McKenzie Towne Family Dental to process a payment to set my outstanding account balance to "zero" by using the given credit card I have provided for any dental claim not paid by my insurance company within 30 days. A receipt for this transaction will be mailed with a paid statement. In order to join our VIP Express Checkout Program, please fill out the following requested information. This information will be kept confidential and used only upon the agreed terms.

I authorize McKenzie Towne Family Dental to keep my signature on file to issue any credit/debit memos, as well as outstanding payments after 30 days after all my insurance claims have been paid, to my Credit Card account. I agree that it is my responsibility to follow up on my account status after 30 days of my visit. I agree to keep McKenzie Towne Family Dental updated with a current credit card. This credit card information will be kept on a separate confidential file that is secure.

Signature of Patient or Responsible Party: _____ Date:_____
Print Patient Name(s) of all family members this applies to: _____

Financial Policy

At McKenzie Towne Family Dental, we are committed to providing the best possible treatment for our patients. Our fees are reasonable and competitive according to Alberta Dentists Association Standards. You are responsible for payment at the end of your dental visit regardless of your insurance company's determination of what is usual and customary unless other arrangements have been made. As a courtesy we will be happy to file your claims with the appropriate insurance company. When possible we will use electronic submission which will speed the process for you and you should receive your insurance reimbursement within a few short days. It is your responsibility to know and understand your dental benefits. As per Canadian Privacy Act Laws, it is you, as the policy holder, who is responsible for notifying us of any changes to your coverage, as well as knowing the various procedures covered under your plan to avoid disappointments with claim reimbursements. We will do our best to assist you with your claims. When appropriate we will file for an estimation of dental benefits for a treatment plan. But please keep in mind that insurance companies do not guarantee anything over the phone or in writing, and therefore any additional costs not covered by your insurance are your responsibility. By signing I authorize "McKenzie Towne Family Dental" to send & receive claims or information to my dental insurance provider via electronic submissions, mail or fax. This is also an authorization for my dependents. I understand I am responsible for all fees for services provided the same day of service. A $25 fee will apply for any cheques returned insufficient funds from your financial institution. We confirm all pre-booked appointments two weeks in advance and appointments 2 business days in advance; **please provide 2 business days' notice of appointment cancellation to avoid a "failed appointment fee" of $100.** We understand each circumstance may vary. We accept: Cash, Debit, American Express, Visa and MasterCard.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.
I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party:_____ Date:_____
Print Patient Name(s) of all family members this applies to: _____

Personal Information Privacy Act

We are committed to protecting the privacy of our patients' personal information and to utilize all personal information in a responsible and professional manner and disclose personal information when permitted or required by law.

Personal Information Procedures

We collect contact, medical and financial information about our patients such as names, home/work addresses, home/work phone numbers, e-mail addresses, date of birth, insurance plan details, health/dental histories, emergency contact information.

* **Contact information** is disclosed to third party health benefit providers and insurance companies, with the consent of the patient, for purposes of submission of claims, for reimbursement or payment of dental care, predetermination of dental treatment, open and update patient files, invoice patients for dental services, process dental claims, and to send reminders to patients concerning the need for further dental treatment.
* **Medical information** is disclosed, with consent of the patient, to other dentists, dental specialists, or health care professionals such as physicians. It is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.
* **Financial information** is collected for payment processing purposes. It is not shared with third parties unless permitted by law for outstanding bill collection purposes.

In the event our dental office ever sells the practice, the new dental practitioner may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale, all personal information will be safeguarded. 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 and that of my dependents.

Signature of Patient or Responsible Party:_____ Date:_____
Print Patient Name(s) of all family members this applies to: _____

THANK-YOU

McKenzie Towne Family Dental
Family, Cosmetic & General Dentistry

McKenzie Towne Family Dental
Family, Cosmetic & General Dentistry

To all of our valued patients with Dental Insurance Plans:

Please take this form home with you or complete prior to your appointment.

In an effort to respect your valuable time, we recommend you call your insurance company and request a breakdown of your dental coverage. Every plan is different! We encourage our patients to be educated about their Dental Insurance to **avoid unexpected bills.** As part of the Health Privacy Act, insurance companies **will not release this information to us** without the plan holder present. Once we have this information, we will have a better understanding of your coverage and will be happy to clarify the following questions.

****Please note: if you do not have your plan details, we will assume you are covered every 6 months for recalls (full cleaning procedures & exam), which may not be the case and you will be held responsible for the unpaid amount.****

Questions to ask your insurance provider:

- How often am I allowed to receive a New Patient exam (code: **01103** - adult, **01102** - mixed adult & baby teeth,

  or **01101** - baby teeth)? _____ Recall Exam (code: **01202**)? _____
- How often am I allowed to have Bitewing X-rays?_____ and PA X-rays?_____
- How often am I allowed to have a Panoramic X-ray? _____
- How many scaling and root planing units am I eligible to receive in a 12 month period? _____
- How often am I covered for Polish (code: **11101**)?_____ and Fluoride (code: **12101**)?_____
- Is there an age restriction for Fluoride? _____
- What is my yearly maximum on my plan? $_____
- What is my basic max? $_____ Major max? $_____ Or is it a combined max? $_____
- What percent coverage do I have for basic? _____% Major? _____%
- When does my plan renew? _____
- Do I have a deductible? _____ If yes, how much? $_____

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McKenzie Towne Family Dental
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If we are DIRECT BILLING your insurance (Option 2), we do require a credit card on file for any remaining balances after insurance payment. Also, our FINANCIAL POLICY, regarding short-notice cancellations and missed appointments, require you to leave a credit card on file that will be charged $100 if you do not provide a 48 hour notice. If you do not have a credit card, we require $100 deposit on your account.

This information will be kept confidential and this hardcopy page will be properly discarded after information is securely stored.

CREDIT CARD TYPE *(please circle)*: VISA / MasterCard / AmEx

NAME OF CARDHOLDER: _____
(as shown on card)

CREDIT CARD NUMBER: _____

EXPIRY DATE *(mo./yr.)*: _____/_____

Please contact us to update information when your credit card expires
APPLIES TO ALL OF THE FOLLOWING FAMILY MEMBERS: (please print patient's full names)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

I agree with the policies outlined in the Financial Policy and authorize McKenzie Towne Family dental to charge my credit card in the event of a short-notice cancellation, missed appointment, and for the remaining balance after insurance payment (unless otherwise specified):

Signature: _____ **Date:** _____