FORT DENTAL
HEALTH GROUP

Patient Information

#201 10010 88th Avenue
Fort Saskatchewan, AB T8L 0A8
P: (780)998-7165 E: info@fortdental.com

* Patient's Name: _____
(FIRST) (LAST) (PREFERRED)

Title: ☐ Mr. ☐ Mrs. ☐ Ms. Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Other

* Birth Date: _____ *Alberta Health Care Number: _____
(dd/mm/yyyy)

*Current Address: _____
(Street/Box#) (City/Town) (Postal Code)

*Email Address: _____ * Preferred Method of Contact: _____
(Phone, Text, or Email

* Phone Number: _____
(Home) (Cell) (Work)

* Emergency Contact: _____ * Emergency Number: _____

* Guardian Information: _____ * Guardian Number: _____

* Insurance Information:

First Insurance Information	Second Insurance Information
Insurance Company: _____	Insurance Company: _____
Group/ Policy # : _____	Group/ Policy # : _____
ID/ Cert. #: _____ Div. #: _____	ID/ Cert. #: _____ Div. #: _____
Policy Holder Full Name and DOB:	Policy Holder Full Name and DOB:
_____	_____
Last First (dd/mm/yyyy)	Last Name (dd/mm/yyyy)

* Please indicate the persons responsible for the account and any billing/payment *

* Name: _____ * Relation: _____ * Number: _____

* Previous Dental Office: _____ * Last Appointment: _____

Is there anything you would like to change about your smile? _____

Consent For Treatment

I authorize and give consent to Fort Dental to perform dental services agreed between the doctor and patient and/or parent or guardian deemed to be necessary or advisable, including the use of local anesthesia and other medication as indicated. I certify the statements regarding medical condition are correct. The information on this page and the medical history is correct to the best of my knowledge.

Insurance Authorization and Authorized Consent to Release Information

As a courtesy to you we direct bill most insurance companies. However, in the event that we are not able to collect for service rendered after 90 days we will forward the bill to you and you will have to deal with your insurance company directly.

_____ _____
* Signature * Date

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Patient Medical Information

1. * **Has there been any change in your general health in the <u>PAST YEAR?</u> Are you being treated for any medical condition OR have you been treated within the <u>PAST YEAR?</u>** ☐ YES ☐ NO
   * IF YES; PLEASE EXPLAIN.

   _____

2. * **Are you taking any medications, non-prescription drugs or supplements of <u>ANY KIND?</u>** ☐ YES ☐ NO
   * IF YES; PLEASE EXPLAIN:

   _____

3. * **Have you ever had a peculiar or adverse reaction to any medications or injections?** ☐ YES ☐ NO
   * IF YES; PLEASE EXPLAIN.

   _____

4. * **Have you ever been hospitalized for any illness or operation in the PAST YEAR?** ☐ YES ☐ NO
   * IF YES; PLEASE EXPLAIN.

   _____

5. * **HAVE YOU BEEN ADVISED BY YOUR DOCTOR TO TAKE ANTIBIOTICS BEFORE DENTAL TREATMENT?** ☐ YES ☐ NO
   * IF YES; PLEASE EXPLAIN.

   _____

* **Do you have or have you ever had any of the following? Please check all that apply**:

- ☐ Anemia
- ☐ Anxiety or Depression
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Blood Disease/ Hemophilia
- ☐ Cancer/ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/ Fainting
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Excessive Bruising
- ☐ Frequent Headaches
- ☐ Gastro-Intestinal
- ☐ Glaucoma
- ☐ Hard to Freeze
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Hearing Impaired
- ☐ Heart Attack OR Surgery
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV + AIDS
- ☐ Hives
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Nervous Disorders
- ☐ No Epinephrine
- ☐ Pace Maker
- ☐ Stroke
- ☐ Radiation Therapy
- ☐ Respiratory Issues
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sinus Issues
- ☐ Skin Rash
- ☐ Shingles
- ☐ Stomach Issues
- ☐ Thyroid Issues
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Wheelchair

ALLERGIES
- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline

OTHER:
_____
_____

Do you Smoke or use Tobacco? [Y] ☐ [N] ☐

IF FEMALE: [Y] [N]
Birth Control? ☐ ☐
Pregnant? ☐ ☐

# of Weeks: _____

Nursing? ☐ ☐

* **Are there any conditions or diseases not listed about? Please List**:

_____

_____ _____

* Signature * Date

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Payment Options

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*** Please Select ONE of the following options below:**

☐ Option 1: I do not have insurance and I will pay the same day. We accept MasterCard, Visa, Debit, Cash, and Cheques for your convenience

☐ Option 2: I have only ONE insurance. As a courtesy to you we direct bill over the internet for instant authorization. **Payment of what is not covered will be made the same day.** If your insurance does not give us instant feedback, you will be asked to pay an estimated co-pay portion based on what is usually covered by your plan.

☐ Option 3: I have TWO insurance. We will directly bill your insurance companies. Once both insurance companies have paid us (Approximately 4 – 6 weeks), any remaining amount will be forwarded in a statement to you via mail or text. **For your convenience you MAY leave your credit card on file for any remaining balances on account to be processed.**

☐ Option 4: I am covered under Treaty, AISH, Alberta Works, Child Health Benefit or Alberta Seniors Dental Program 101. There will be no balance unless receiving treatment outside of the government funded program fee guide, which will be discussed prior to treatment.

Payment for All Treatment and Services rendered are my responsibility. Please Read.

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.
I understand that I am responsible for all costs of dental treatment not covered by my insurance carrier. I hereby authorize payment directly to Fort Dental from my group insurance benefits otherwise payable to me. If my insurance pays me directly, I will be responsible for the total balance.

Payment for all treatment and services are my responsibility if my insurance plan does not pay within 90 days or my coverage has been terminated.

I, _____, have chosen OPTIONS 2/3, and I hereby authorize any balances not
*(PRINTED FULL NAME)
Covered by my insurance for me and/or my family members to automatically be applied to the following credit card:

Card Type: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS

Name: _____
(AS IT APPEARS ON CARD)

Card Number: _____
Expiry Date: _____ CVC Number: _____

_____ _____
* Signature * Date