GARDEN DENTAL
& ORTHODONTICS

Thank you for choosing Garden Dental & Orthodontics and for giving us the opportunity to provide you with outstanding dental care. Please let us know if there is anything we can do to make today's visit more comfortable for you.

INFORMATION YOU GIVE US IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR WRITTEN PERMISSION. TO HELP US PROVIDE YOU WITH THE BEST DENTAL CARE POSSIBLE, PLEASE PROVIDE US WITH COMPLETE INFORMATION AND DON'T SKIP ANY QUESTIONS. WE WILL REVIEW THE QUESTIONNAIRE AND DISCUSS IT WITH YOU IN DETAIL. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK THE DENTIST.

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Yellow Pages ☐ Newspaper ☐ Radio ☐ Walk-in ☐ Friend
☐ Internet Search ☐ Facebook ☐ Instagram ☐ Referred by

PATIENT INFORMATION

☐ Mr ☐ Mrs ☐ Ms ☐ Dr	Date of Birth DD / MM / YYYY	Last Name
First And Middle Names:		Preferred Name
Home Address		
City	Province	Postal Code
☐ Home Phone	☐ Work Phone	☐ Cell Phone
Email ☐ I would like to receive notifications and appointment reminders by email		
Employer		Occupation
IN CASE OF EMERGENCY, PLEASE NOTIFY:		
Name		Relationship to Patient
Daytime Phone		Other Phone
PERSON RESPONSIBLE FOR THIS ACCOUNT: ☐ Patient		(if someone other than patient, please complete the section below)
Last Name		First And Middle Names
Relationship to Patient		Date of Birth DD / MM / YYYY

Home Address		
City & Province		Postal Code
☐ Home Phone	☐ Work Phone	☐ Cell Phone
Employer	Is this person a patient at our office? ☐ YES ☐ NO	

CONSENT:

☐ **I certify that I have provided an accurate and complete personal, medical and dental history and have not knowingly omitted any information.**

☐ **I hereby authorize the taking of radiographs (x-rays), study models, photographs or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.**

☐ **I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic as indicated and I will assume responsibility for fees associated with those procedures. I understand that the use of medications, anesthetics and some procedures embody a certain risk. I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment the dentist and I understand that payment for these additional procedures is my responsibility.**

➡ **PATIENT/ PARENT/GUARDIAN SIGNATURE:** _____ **DATE** _____

MEDICAL HISTORY

1. When was your last medical examination?	2. Purpose:
3. Have you been treated for any medical condition within the past year? ☐ YES ☐ NO	Details
4. Have you traveled outside Canada within the last year? ☐ YES ☐ NO	Destination
5. Have you had an unusual or persistent cough or rash in the past 3 weeks that has not been examined by your family doctor? ☐ YES ☐ NO	
6. Has there been any change in your general health in the past year? ☐ YES ☐ NO	Details
7. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ☐ YES ☐ NO	Please list

8. Are you allergic to or have you had adverse reactions to any of the following? (please check all that apply):

☐ Local Anaesthetics ☐ Barbiturates or Sedatives ☐ Penicillin or Other Antibiotics ☐ Aspirin ☐ Iodine

☐ Bisphosphonates ☐ Latex or Rubber ☐ Codeine ☐ Sulfa Drugs

☐ Any metals (like Nickel, Mercury etc) ☐ Other (please list)

9. Have you ever had a peculiar or adverse reaction to any medications or injection/anaesthetic? ☐ YES ☐ NO	Details
10. Do you have, or have you ever had, endocarditis, a prosthetic heart valve, heart transplant or other heart surgery? ☐ YES ☐ NO	
11. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO	
12. Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ YES ☐ NO	
13. Do you have any conditions or therapies that could affect your immune system like leukemia, radiotherapy, chemotherapy, transplant surgery? ☐ YES ☐ NO	
14. Do you have a bleeding problem or bleeding disorder? Do you bruise easily? ☐ YES ☐ NO	
15. Have you ever been hospitalized for any serious illness or major surgery? ☐ YES ☐ NO	Details

16. Do you have or have you ever had any of the following? (Please check all that apply)

☐ heart disease	☐ hepatitis	☐ chest pain, angina	☐ shortness of breath	☐ pacemaker
☐ steroid therapy	☐ seizures(epilepsy)	☐ heart attack	☐ lung disease	☐ diabetes
☐ kidney disease	☐ tuberculosis	☐ thyroid disease	☐ swollen ankles/feet/hands	
☐ stroke	☐ stomach ulcers	☐ anxiety disorder	☐ eating disorder	☐ low blood sugar
☐ drug dependency	☐ alcohol dependency	☐ glaucoma	☐ cancer	☐ arthritis
☐ diet pill therapy	☐ asthma	☐ HIV/AIDS,	☐ rheumatic fever	☐ liver disease
☐ jaundice	☐ cochlear implant	☐ high/low blood pressure		
☐ other (please describe)				

17. Are there any disease or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ YES ☐ NO	Details
18. Do you smoke or chew tobacco products? ☐ YES ☐ NO	Details
19. *For women only*: Are you breast-feeding or pregnant? ☐ YES ☐ NO	Due Date
20. Do you have any other disease, disorder or condition not listed above? ☐ YES ☐ NO	Details

Please indicate your 21. Height ft in 22. Weight lbs

☐ **I understand the need for these questions to be answered truthfully and that providing inaccurate information can be dangerous to my health. To the best of my knowledge, the answers I have given are complete and accurate. I also understand that it is my responsibility to inform Garden Dental of any changes or updates in my medical status, including new medications.**

➡ **PATIENT/ PARENT/GUARDIAN SIGNATURE:** _____ **DATE** _____

➡ **DENTIST SIGNATURE:** _____ **DATE** _____

DENTAL HISTORY

What is the reason for today's visit to our office?							
Before today, when was your last dental visit and what was done at that visit?							
Who was your previous dentist? (Name and Location)							
How often to do you schedule routine dental visits?	☐ every 3 months	☐ every 6 months	☐ every 12 months	☐ never			
How would you rate your overall oral health?	☐ excellent	☐ good	☐ fair	☐ poor			
How often do you	brush your teeth? times a day/week		floss? times a day/week		use mouthwash? times a day/week		
Do you have any of the following?	☐ complete denture	☐ partial denture	☐ bridge	☐ implant			
How fearful are you of dental treatment?	(*extremely fearful*) ☐ 10	☐ 9	☐ 8	☐ 7	☐ 6	☐ 5	☐ 4 ☐ 3 ☐ 2 ☐ 1 (*not at all*)
Have you had an unfavourable or traumatic dental experience? ☐ YES ☐ NO							
Have you had any difficult extractions or prolonged bleeding during dental visits? ☐ YES ☐ NO					Do you have a very sensitive gag reflex? ☐ YES ☐ NO		
Have you ever had trouble getting numb /had any adverse reaction to local anaesthetic? ☐ YES ☐ NO					Do you have trouble lying flat in the dental chair? ☐ YES ☐ NO		

YOUR BITE AND JAW (Please check all that apply to you)

☐ I have noticed a clicking or popping noise in my jaw	☐ I have frequent headaches, sometimes even when waking up
☐ I have difficulty opening or closing my mouth	☐ I find myself clenching or grinding my teeth
☐ I have problems chewing tough foods like bagels	☐ I frequently bite my lips or cheeks
☐ I have noticed shifting in the position of my teeth	☐ I have had head, neck or jaw injuries
☐ I have had braces or had my bite adjusted	☐ I have worn a bite plate, mouth guard or other appliance

YOUR TOOTH STRUCTURE (Please check all that apply to you)

☐ My mouth seems dry and/or I have trouble swallowing food	☐ I find that food tends to get caught between my teeth
☐ My teeth are sensitive to hot or cold foods or liquids	☐ I have broken or chipped a tooth or had a cracked filling in the past
☐ My teeth are sensitive to sweet or sour foods or liquids	

YOUR GUMS AND BONE (Please check all that apply to you)

☐ My gums bleed when brushing or flossing	☐ I have sores, bleeding, pus or lumps in or near my mouth
☐ I have been treated for periodontal (gum) disease	☐ I suffer from bad breath or an unpleasant taste in my mouth
☐ Some of my teeth feel loose	

YOUR SMILE (Please check all that apply to you)

☐ I have whitened my teeth in the past (at home or a dental office)	☐ I am embarrassed to smile or uncomfortable about the appearance of my teeth
☐ I would like to change the appearance of my teeth	

INSURANCE INFORMATION

Do you have Insurance Coverage? ☐ YES ☐ NO	Are you claiming from more than one insurance company? ☐ YES ☐ NO
Have you used your Insurance at another office during the current coverage term? ☐ YES ☐ NO	Name of Dental Clinic
PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name of Patient	Name of Patient
Relationship to Policy Holder ☐ Spouse ☐ Dependant	Relationship to Policy Holder ☐ Spouse ☐ Dependant
Insurance Company	Insurance Company
Policy Number/Group #	Policy Number/Group #
Subscriber ID/Certificate #	Subscriber ID/ Certificate #
Name of Policy Holder	Name of Policy Holder
Policy Holder Date of Birth DD / MM / YYYY	Policy Holder Date of Birth DD / MM / YYYY
Employer	Employer

PAYMENT (PLEASE CHECK EACH BOX TO ACKNOWLEDGE THAT YOU ACCEPT THESE TERMS)

☐ I understand that Garden Dental offers different forms of payment to make their services more affordable for patients and confirm that I will address any concerns regarding payment with the financial coordinator before treatment is started.

☐ Regardless of method of payment, I agree to unconditionally pay for services rendered, irrespective of payment by insurance carriers, workers compensation etc.

☐ I also agree to pay for services when they are rendered unless other arrangements have been made with the financial coordinator in advance. I understand that financial charges will be added to my account for delinquent payment. I further agree to pay for attorney's fees and collection costs in the event I fail to pay or my insurance fails to pay my account in full within 60+ days of receipt of services.

☐ I understand that Garden Dental will submit claims to my insurance carrier on my behalf and acknowledge that it might be necessary to resubmit a claim for any number of reasons. In the event of a resubmission, I understand that I might be required to sign a claim form and I understand that failure to sign the claim form in a timely matter will result in all outstanding charges to be transferred to me immediately without prior notice.

☐ I understand that Garden Dental requires a current credit card on file, and I consent to automatic billing of outstanding balances of less than $100. If the balance is more than $100, I understand that the office will notify me as a courtesy before charging the balance to my credit card.

☐ I understand that Garden Dental will make treatment recommendations based on our professional assessment of my dental needs, and not necessarily based on my coverage.

☐ I understand that Garden Dental may not have access to information about my specific policy and coverage information, and I agree to assist in every way possible to provide accurate information about my coverage.

➡ **PATIENT/ PARENT/GUARDIAN SIGNATURE:** _____ **DATE** _____

AUTHORIZATION

☐ I confirm that, to the best of my knowledge, the above information is correct. I authorize the release of information contained in claims submitted electronically to my dental benefits plan administrator and CDA. I also authorize the communication of information related to the coverage of services described to the named dentist.

☐ I hereby assign my benefits, payable from claims submitted electronically, to Dr Morris and authorize payment directly to him. The authorization shall continue in effect until the undersigned revoke the same.

➡ **PATIENT/ PARENT/GUARDIAN SIGNATURE:** _____ **DATE** _____

FOR OFFICE USE ONLY	DATE ENTERED DD / MM / YYYY	NAME

CANCELLATION AND NO SHOW POLICY

Our goal is to provide quality dental care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of dental care.

Definition of a No Show: Our definition of a No Show is a patient who: does not show up for their scheduled appointment, cancels or reschedules their appointment with less than 24 hours notice, or shows up more than 20 minutes late for the appointment.

Cancellation of an Appointment: In order to be respectful of the dental needs of other patients, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely dental care.

Appointment Confirmations: As a courtesy, we will attempt to remind you of your appointment by calling, emailing or texting you 1 or 2 days prior to confirm your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event that your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for you and in the event that we are unsuccessful in our efforts to confirm your appointment, it is still your responsibility to keep the appointment.

☐ **I, _____ understand that when I make an appointment, it is my responsibility to ensure that I keep the appointment, regardless of whether I receive a reminder from Garden Dental or not. I acknowledge that Garden Dental requires 24 hour advance notice if I am unable to keep a scheduled appointment. I understand that if I continuously fail to keep a scheduled appointment, I may lose the privilege of scheduling appointments, and only be able attend the office for same-day appointments.**

➡ **PATIENT/ PARENT/GUARDIAN SIGNATURE:** _____ **DATE** _____

PRIVACY AND CONSENT

At Garden Dental, we are committed to providing our patients with exceptional service. Providing this service involves the collection, use and disclosure of some personal information about our patients, and protecting their personal information is one of our highest priorities.

Alberta's Personal Information Protection Act (PIPA). PIPA, which came into effect on January 1, 2004, sets out the ground rules for how Alberta businesses and not-for-profit organizations may collect, use and disclose personal information.

We will inform our patients of why and how we collect, use and disclose their personal information, obtain their consent where required, and only handle their personal information in a manner that a reasonable person would consider appropriate in the circumstances.

We collect information from our patients such as names, home addresses, work 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 relating to the need for further dental examination or treatment.
To send patients informational material about our dental practice.

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 requested that we submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services. Financial information is stored in a

We collect information from our patients about their medical history, their family medical history, physical condition, and dental treatments (collectively referred to as "Medical Information"). Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information may be 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 requested that we 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.

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/me dependant's personal information as set out above**

➡ **PATIENT/ PARENT/GUARDIAN SIGNATURE:** _____ **DATE** _____