Patient Information Form

Today's Date ____________________

Patient Name: First____________________MI_____Last____________________Preferred____________________

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Married. ☐ Single. ☐ Other____________________

Address: Street____________________City____________________Prov.__________Postal Code__________

Phone: Home____________________Work____________________Mobile____________________

E-mail address ____

***By Providing your e-mail address you agree to receive appointment reminders.**

What is your preferred method of contact for appointment reminders? ☐ Text Message ☐ Email ☐ Both

Who may we thank for referring you? ____

Alberta Healthcare Number____________________**Date of Birth (dd/mm/yy)** ____________________

Employer____________________**Occupation** ____________________

In case of emergency, who should be notified? ____

Relationship to Patient____________________**Home Phone**____________________**Mobile Phone** ____________________

Is the patient a Minor? ☐ Yes ☐ No **Full-time Student** ☐ Yes ☐ No **Institution**: ____________________

Name of Responsible Party/Guardian: First____________________Last____________________

Relationship to Patient ____________________

If patient is a Minor, primary residency ☐ Both Parents ☐ Mom ☐ Dad ☐ Step Parent ☐ Shared Custody ☐ Guardian

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Dental Benefit Plan Information – Please provide this information to reception.

Informed Consent

- I, the undersigned, hereby authorize the dentist or his/her staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.
- I authorize the dentist or his/her staff to perform and apply any and all forms of treatment, medication and therapy (within their scope of practice) that may be indicated and consent to the use of local anesthetic.
- I understand that although the dentist and staff do a comprehensive exam, my treatment plan may change during treatment as the extent of some conditions cannot be known prior. If a change from the original treatment plan occurs, the dentist or staff will inform me. I am welcome to ask questions about any aspect of my dental care and am responsible for clarifying any aspect of my treatment I'm unsure about.
- I understand and accept the responsibility that payment for dental services for myself as well as my dependant is due and payable when services are rendered unless other financial arrangements have been made. Should I have dental insurance with the assignment to Dr. Ross Donison Professional Corporation, the estimated patient portion will be the amount due.
- I understand I am responsible for understanding my insurance policy and do not hold Donison Dental accountable for limitations with my plan. It is my responsibility to deal directly with my insurance company when complications occur.

Name: ____________________ **Date:** ______________ **Signature:** ____________________

Patient Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. 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 us "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 the reminders to the patients concerning 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 asked us to submit a claim on the patient's behalf.

Financial information is collected for payment processing purposes. it is not shared with third parties without your consent, unless permitted by law for outstanding bill collection purposes.

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

Patients' Medical 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 asked us to submit a claim on the patient's behalf.
- With the consent of the patient, to other dentists and dental specialists, or to other health care professionals.
- If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take step to ensure that the prospective purchaser safeguards all personal information.

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.

Name: ________________________ Date: ____________ Signature: ___________________________