



# Hollick-Kenyon Dental Clinic

## CONTACT INFORMATION

FIRST NAME:		LAST NAME:		MIDDLE INITIAL:
NICKNAME:	STATUS: Single <input type="checkbox"/> Married <input type="checkbox"/> Child <input type="checkbox"/> Common Law <input type="checkbox"/>	DOB:		SEX: Male <input type="checkbox"/> Female <input type="checkbox"/>
Home #		Cell #	Work #	
EMAIL:				
ADDRESS:		CITY/PROV:		POSTAL:
EMERGENCY CONTACT:		RELATIONSHIP:	NUMBER:	
HOW DID YOU HEAR ABOUT US?				

## HEALTH INFORMATION

HOW WOULD YOU RATE YOUR GENERAL HEALTH?      EXCELLENT       GOOD       FAIR       POOR

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (PLEASE CHECK THOSE THAT APPLY BELOW)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> HOSPITALIZATION FOR ILLNESS OR INJURY   | <input type="checkbox"/> STOMACH OR DUODENAL ULCER  | <input type="checkbox"/> ALCOHOL USE                         |
| <input type="checkbox"/> HEART PROBLEMS, OR CARDIAC STENT        | <input type="checkbox"/> DIGESTIVE DISORDER   | <input type="checkbox"/> CANNABIS OR OTHER DRUG USE          |
| <input type="checkbox"/> HISTORY OF INFECTIVE ENDOCITIS          | <input type="checkbox"/> OSTEOPOROSIS/OSTEOPENIA  | <input type="checkbox"/> MEDICATION FOR WEIGHT LOSS          |
| <input type="checkbox"/> ARTIFICIAL VALVE, REPAIRED HEART DEFECT | <input type="checkbox"/> ARTHRITIS  | <input type="checkbox"/> DIETARY SUPPLEMENTS                 |
| <input type="checkbox"/> PACEMAKER/IMPLANTABLE DEFIBULATOR       | <input type="checkbox"/> AUTOIMMUNE DISEASE   | <input type="checkbox"/> OFTEN EXHAUSTED OR FATIGUED         |
| <input type="checkbox"/> ORTHOPEDIC IMPLANT                      | <input type="checkbox"/> GLAUCOMA   | <input type="checkbox"/> EXPERIENCE FREQUENT HEADACHES       |
| <input type="checkbox"/> RHEUMATIC OR SCARLET FEVER              | <input type="checkbox"/> DIABETES   | <input type="checkbox"/> SMOKER OR PREVIOUSLY SMOKED         |
| <input type="checkbox"/> HIGH BLOOD PRESSURE                     | <input type="checkbox"/> HEAD OR NECK INJURIES  | <input type="checkbox"/> USE SMOKELESS TOBACCO               |
| <input type="checkbox"/> LOW BLOOD PRESSURE                      | <input type="checkbox"/> EPILEPSY, CONVULSIONS  | <input type="checkbox"/> FEMALE – TAKING BIRTH CONTROL       |
| <input type="checkbox"/> STROKE                                  | <input type="checkbox"/> NEUROLOGIC DISORDERS (ADD/ADHD)  | <input type="checkbox"/> MALE – PROSTATE DISORDERS           |
| <input type="checkbox"/> BLOOD THINNERS                          | <input type="checkbox"/> VIRAL INFECTIONS/COLD SORES  | <b>ALLERGIES</b>   |
| <input type="checkbox"/> ANEMIA OR BLOOD DISORDER                | <input type="checkbox"/> HIVES/SKIN RASH/HAY FEVER  | <input type="checkbox"/> ASPIRIN, IBUPROFEN, ACETAMINOPHEN   |
| <input type="checkbox"/> PROLONGED BLEEDING W/ SLIGHT CUT        | <input type="checkbox"/> STI/STD/HPV  | <input type="checkbox"/> CODIENE                             |
| <input type="checkbox"/> EMPHYSEMA, SHORTNESS OF BREATH          | <input type="checkbox"/> HEPATITIS A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> | <input type="checkbox"/> ERYTHROMYCIN                        |
| <input type="checkbox"/> TUBERCULOSIS, MEASLES, CHICKEN POX      | <input type="checkbox"/> HIV/AIDS   | <input type="checkbox"/> TETRACYCLIN                         |
| <input type="checkbox"/> ASTHMA                                  | <input type="checkbox"/> TUMORS/ABNORMAL GROWTH   | <input type="checkbox"/> SULFA                               |
| <input type="checkbox"/> BREATHING/SLEEPING PROBLEMS (APNEA)     | <input type="checkbox"/> RADIATION THERAPY  | <input type="checkbox"/> LOCAL ANESTHETIC                    |
| <input type="checkbox"/> KIDNEY DISEASE                          | <input type="checkbox"/> CHEMOTHERAPY   | <input type="checkbox"/> FLUORIDE                            |
| <input type="checkbox"/> LIVER DISEASE                           | <input type="checkbox"/> IMMUNOSUPPRESSIVE MEDICATION   | <input type="checkbox"/> METALS (NICKEL, GOLD, SILVER, ETC.) |
| <input type="checkbox"/> THYROID/PARATHYROID/CALCIUM DEFICIENT   | <input type="checkbox"/> EMOTIONAL DIFFICULTIES   | <input type="checkbox"/> PENICILLIN                          |
| <input type="checkbox"/> HORMONE DEFICIENCY                      | <input type="checkbox"/> PSYCHIATRIC TREATMENT  | <input type="checkbox"/> LATEX                               |
| <input type="checkbox"/> HIGH CHOLESTEROL/TAKING SATIN DRUGS     | <input type="checkbox"/> ANTIDEPRESSANT MEDICATION  | <input type="checkbox"/> OTHER: _____                        |

DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_ FEMALE: ARE YOU PREGNANT? IF YES, DUE DATE: \_\_\_\_\_

HAVE YOU EVER HAD ANY COMPLICATIONS FOLLOWING DENTAL TREATMENT? Y  N  IF YES, PLEASE EXPLAIN: \_\_\_\_\_

HAVE YOU EVER BEEN ADMITTED TO A HOSPITAL OR NEEDED EMERGENCY CARE IN THE PAST TWO YEARS? Y  N  IF YES, PLEASE EXPLAIN: \_\_\_\_\_

ARE YOU UNDER THE CARE OF A PHYSICIAN? Y  N  IF YES, PLEASE EXPLAIN: \_\_\_\_\_

NAME OF PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

DO YOU HAVE ANY HEALTH PROBLEMS THAT NEED FURTHER CLARIFICATION? Y  N  IF YES, PLEASE EXPLAIN: \_\_\_\_\_

LIST ALL MEDICATIONS, SUPPLEMENTS, AND VITAMINS YOU HAVE TAKEN IN THE PAST TWO YEAR'S: \_\_\_\_\_

**TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT. IF I EVER HAVE A CHANGE IN MY HEALTH OR PERSONAL INFORMATION, I WILL INFORM THE CLINIC BEFORE MY APPOINTMENT WITHOUT FAIL.**

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_



# Hollick-Kenyon Dental Clinic

## OFFICE POLICIES

Name: \_\_\_\_\_

\*UPDATED AUGUST 2019

**\*\*\*PLEASE REVIEW YOUR DENTAL PLAN VERY CAREFULLY TO ENSURE YOU UNDERSTAND THE EXCLUSIONS & LIMITATIONS OF YOUR PLAN\*\*\***

- ☞ Patient's that carry dental insurance understand that all dental services provided are charged directly to the patients and that they are personally responsible for all dental services.
- ☞ This office will help prepare the patient's insurance forms or assist in making collections from the insurance and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that your charges will be paid by your insurance company.
- ☞ As a patient of this clinic, it is important to understand that Hollick-Kenyon Dental cannot be responsible for your insurance maximums, frequencies, or each procedures eligibility. You are solely responsible to keep track of how much you have used per benefit year.
- ☞ If you would like an estimate sent to your insurance, please inform the administration team every time you would like one completed. Due to the Privacy Act, your insurance may not release details to us regarding your plan. It is your responsibility to forward us any information your insurance company has provided to you.
- ☞ If we do not have an estimate on file for any major work such as; crowns, bridges, dentures, implants, we will require payment in full and we will have your insurance reimburse you directly.
- ☞ Estimates on your file can only be extended for a period of 6 months from the date of the examination.
- ☞ Dentistry is not an exact science and there may be complications that are at no fault of the dentist. You understand no guarantee has been made by Hollick-Kenyon Dental regarding treatment.
- ☞ For your first cleaning, it is impossible to gauge how much time you will need to finish. Since everyone's mouth is vastly different, you may require more than one visit to complete your cleaning.
- ☞ A procedure can change during the course of an appointment depending on the difficulty. Therefore, the fee may also change. We will do our best to inform you of any changes and allow you to make an informed decision on your course of treatment. However, any fee changes are the sole responsibility of the patient.
- ☞ You authorize the staff to perform any necessary services needed during diagnosis and treatment.
- ☞ Hollick-Kenyon Dental takes pride in our cleanliness and standard of care. We ask all parents to wait in the lounge as their child is getting treatment so we may keep our area sterilized and open to properly function.
- ☞ You authorize text and email reminders as well as, minimal promotional emails through a third-party communication provider.
- ☞ You consent to your initial photograph being taken so we may prevent insurance fraud.
- ☞ You give staff at Hollick-Kenyon Dental permission to leave a voicemail to discuss appointment times, treatment and costs, balances, insurance issues, etc.
- ☞ All children under the age of 18 must be accompanied by a parent or legal guardian. This is so we can obtain signatures for insurance and consent forms. Parents are not permitted to leave the office while their child is getting treatment completed.
- ☞ We are committed to providing a safe environment where all staff and patients feel valued and respected. The clinic will not tolerate any discrimination, hostility, or harassment that will undermine the dignity, self-esteem or productivity of any staff or patient of the office. We consider any of these behaviors a serious breach of human rights, which may result in discharge from the clinic.
- ☞ **CANCELLATION POLICY:** To ensure patients are given an equal opportunity to be seen and sufficient use of the healthcare provider recourses are utilized, we require a confirmation that you will be here for your appointment via email, text, or phone call. Reminders will be sent out well in advance. If you need to change or cancel an appointment, please give us a minimum of **48 business hours' notice**. Short notice cancellations and no shows may result in a fee up to \$150.00 that will be assessed and associated to your account. You may also run the risk of losing your booked appointment if we do not obtain a confirmation up to at least 24 hours before the appointment or if you are too late. In the event there is a pattern of missed appointments, we will see you same day only or require a deposit before booking any appointments for the future.

*By signing below, you certify that you have read or have had read to you the contents of this form and you agree in its entirety. You have had the opportunity to ask any questions you may have and are satisfied with proceeding as a patient with Hollick-Kenyon Dental. You consent to having your dental treatment provided by Hollick-Kenyon Dental and realize the risks and limitations. You understand you may withdraw your consent at any time in writing or by email.*

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_



# Hollick-Kenyon Dental Clinic

## DENTAL HISTORY

### 18+ ONLY & FULL-MOUTH EXAMS

Name:	Age:	Immediate concern:		
Date of last exam & x-rays:		Date of last treatment (not cleaning):		
Previous Dentist:	How long were you a patient?	Reason for leaving?		
How long do you routinely see a dentist? 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Not routinely <input type="checkbox"/>				
How would you rate the condition of your mouth? Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>				

**PLEASE CHECK YES OR NO TO THE FOLLOWING:** (Dentist only)

R   Y   G   YES   NO

PERSONAL HISTORY	R	Y	G	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale from 1 (least) – 10 (most) _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
2. Have you ever had an unfavorable dental experience?					
3. Have you ever had complication from past dental treatment?					
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?					
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?					
6. Have you had any teeth removed?					

GUM AND BONE	R	Y	G	YES	NO
7. Do your gums bleed or are they painful when brushing or flossing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?					
9. Have you ever notices and unpleasant taste or odor in your mouth?					
10. Is there anyone with a history of periodontal disease in your family?					
11. Have you ever experienced gum recession?					
12. Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple?					
13. Have you experienced a burning sensation in your mouth?					

TOOTH STRUCTURE	R	Y	G	YES	NO
14. Have you had any cavities within the past 3 years?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?					
16. Do you feel or notice any holes (ex. pitting, craters) on the biting surface of your teeth?					
17. Do you have any grooves or notches on your teeth or near your gum line?					
18. Have you ever broken teeth chipped teeth or had a toothache or cracked filling?					
19. Do you frequently get food caught between any teeth?					
20. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?					

BITE AND JAW JOINT	R	Y	G	YES	NO
21. Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?					
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, jerky, hard candy, or dry foods?					
24. Have your teeth changed in the past 5 years, become shorter, thinner or worn?					
25. Are your teeth developing spaces or becoming looser?					
26. Are your teeth becoming more crooked, crowded, or overlapped?					
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?					
28. Do you place your tongue between your teeth or close your teeth against your tongue?					
29. Do you chew ice, bite your nails, and use your teeth to hold objects, or have any other oral habits?					
30. Do you clench your teeth in the daytime?					
31. Do you have any problems with sleep (ex. restlessness), wake up with a headache or an awareness of your teeth?					
32. Do you wear or have you ever worn a bite appliance?					

SMILE CHARACTERISTICS	R	Y	G	YES	NO
33. Is there anything about the appearance of your teeth that you would like to change?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
34. Have you ever whitened (bleached) your teeth?					
35. Have you ever felt uncomfortable or self-conscious about the appearance of your teeth?					
36. Have you ever been disappointed with the appearance of previous dental work?					

DENTIST'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_



**Hollick-Kenyon Dental**  
🦷 **PERSONAL INFORMATION CONSENT** 🦷

Name: \_\_\_\_\_

We are committed to protecting the privacy of our patients' personal information and utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law. The information is being collected under the authority of sections 20 {b} and 21(1) the *Health Information Act (HIA)*. The provisions of the *HIA* protect your privacy and the confidentiality of your Health Information.

We collect information from our patients such as names, home addresses, home and/or work telephone numbers, emails, etc. (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 and/or legal guardians or persons financially responsible for patient accounts, for dental services, to process credit card payments, or to collect unpaid accounts.
- 🦷 To process claims for payment or reimbursement from third-party benefit providers, insurance companies and government agencies.
- 🦷 To send reminders to 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 may be collected in order to make arrangements for the payment of dental services from whoever has been written for financially responsible for the account.

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

**Patients' Medical Information is disclosed:**

- 🦷 To all third-party benefit providers, insurance companies where a claim is being submitted for reimbursement or payment of all or part of the cost of dental treatment.
- 🦷 To other dentists and dental specialists, where further information and/or discussion is required.
- 🦷 To other health care professionals such as physicians if the patient has been referred by us to the other health care professional for either a second opinion or treatment.
- 🦷 Where we are seeking and/or providing information to laboratories, radiology centres, hospitals, etc.
- 🦷 To include the following when necessary, such as: videos, pictures, slides etc., for educational purposes.

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 steps to ensure the prospective purchaser safeguards all personal information.

Hollick-Kenyon Dental is protected by 24-hour video surveillance. All activities recorded may be used to aid the clinic in the prosecution of any crime committed in this facility. It may also be used in the court of law as evidence in a lawsuit with a patient, custodian, or any other affiliates. By entering our clinic, you understand and consent to being video recorded. After a period of time has lapsed, all video recordings are permanently destroyed.

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 interests.

***I consent to the collection, use and disclosure of my personal information as set out above. This includes all dependant family members affiliated to my account.***

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_



# Hollick-Kenyon Dental

## FINANCIAL AGREEMENT

### \*ONE PER FAMILY

Hollick-Kenyon Dental is pleased to offer you the following payment options:

#### Option 1: DIRECT BILL TO INSURANCE

- This option allows us to offer you the convenience of using your insurance plan. **We will require your credit card to be left on file - VISA DEBIT, VISA, MASTERCARD, & AMEX are accepted.** Your credit card will be kept in a secure portal with Moneris. If we receive a response directly after your appointment, you will pay your balance right away. If we do not get a response, we will wait until we get payment from your insurance and then deduct your portion owing off your credit card. We also reserve the right to ask you to make a deposit towards your treatment. After services are rendered, your insurance company will send you an explanation of benefits. This will show you what they paid well before the payment is deducted. If you would like to know why there is a portion, please view your documents provided by insurance and contact them directly. If there is an issue with your insurance, we will contact you to inform you. We will require a call back within 5 business days otherwise, you may be subject to paying the entire balance. If your credit card declines more than one time, we will no longer be able to offer direct billing. Please ensure you keep your information updated with the administration team.

#### Option 2: PAY IN FULL

- Your insurance company may require you to, or you may prefer to, pay for your entire dental bill directly on your credit card and have your insurance company reimburse you. Hollick-Kenyon Dental will process your payment on the day treatment is rendered. Our team will assist you in submitting all the necessary paperwork to your insurance carrier.

*No insurance or have major treatment to book back for?*

You can make pre-payments towards your treatment prior to your appointment.

OR

You can apply for affordable financing through DentalCard (please ask the administration team for more information).

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I \_\_\_\_\_ have chosen option 1, and I hereby authorize Hollick-Kenyon Dental to deduct any balances owed off my credit card to the clinic for services rendered.

CC last 4 digits: \_\_\_\_\_ EXP: \_\_\_\_\_/\_\_\_\_\_ CVD: \_\_\_\_\_

Email: \_\_\_\_\_ Best # to contact: \_\_\_\_\_

The credit card left on file will include all family members unless otherwise advertised in writing. Short notice cancellations and missed appointment charges may also be applied.

**By signing this agreement, you agree and understand the financial agreement fully. You have had the chance to have your questions answered to your full satisfaction.**

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN \_\_\_\_\_ DATE: \_\_\_\_\_