Hollick-Kenyon Dental Clinic

CONTACT INFORMATION

FIRST NAME:	LAST NAME:		MIDDLE INITIAL:
NICKNAME:	STATUS: Single □ Married □ Child □ Common Law □	DOB:	SEX: Male □ Female □
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)

- ☐ HOSPITALIZATION FOR ILLNESS OR INJURY
- ☐ HEART PROBLEMS, OR CARDIAC STENT
- ☐ HISTORY OF INFECTIVE ENDOCATITIS
- ☐ ARTIFICIAL VALVE, REPAIRED HEART DEFECT
- ☐ PACEMAKER/IMPLANTABLE DEFIBULATOR
- ☐ ORTHOPEDIC IMPLANT
- ☐ RHEUMATIC OR SCARLET FEVER
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ STROKE
- ☐ BLOOD THINNERS
- ☐ ANEMIA OR BLOOD DISORDER
- ☐ PROLONGED BLEEDING W/ SLIGHT CUT
- ☐ EMPHYSEMA, SHORTNESS OF BREATH
- ☐ TUBERCULOSIS, MEASLES, CHICKEN POX
- ☐ ASTHMA
- ☐ BREATHING/SLEEPING PROBLEMS (APNEA)
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ THYROID/PARATHYROID/CALCIUM DEFICIENT
- ☐ HORMONE DEFICIENCY
- ☐ HIGH CHOLESTEROL/TAKING SATIN DRUGS
- ☐ STOMACH OR DUODENAL ULDER
- ☐ DIGESTIVE DISORDER
- ☐ OSTEOPOROSIS/OSTEOPENIA
- ☐ ARTHRITIS
- ☐ AUTOIMMUNE DISEASE
- ☐ GLAUCOMA
- ☐ DIABETES
- ☐ HEAD OR NECK INJURIES
- ☐ EPILEPSY, CONVULSIONS
- ☐ NEUROLOGIC DISORDERS (ADD/ADHD)
- ☐ VIRAL INFECTIONS/COLD SORES
- ☐ HIVES/SKIN RASH/HAY FEVER
- ☐ STI/STD/HPV
- ☐ HEPATITIS A □ B □ C □
- ☐ HIV/AIDS
- ☐ TUMORS/ABNORMAL GROWTH
- ☐ RADIATION THERAPY
- ☐ CHEMOTHERAPY
- ☐ IMMUNOSUPRESSIVE MEDICATION
- ☐ EMOTIONAL DIFFICULTIES
- ☐ PSYCHIATRIC TREATMENT
- ☐ ANTIDEPRESSANT MEDICATION
- ☐ ALCOHOL USE
- ☐ CANNABIS OR OTHER DRUG USE
- ☐ MEDICATION FOR WEIGHT LOSS
- ☐ DIETART SUPPLEMENTS
- ☐ OFTEN EXHAUSTED OR FATIGUED
- ☐ EXPERIENCE FREQUENT HEADACHES
- ☐ SMOKER OR PREVIOUSLY SMOKED
- ☐ USE SMOKELESS TOBACCO
- ☐ FEMALE – TAKING BIRTH CONTROL
- ☐ MALE – PROSTATE DISORDERS

ALLERGIES

- ☐ ASPIRIN, IBUPROFEN, ACETAMINOPHEN
- ☐ CODIENE
- ☐ ERYTHROMYCIN
- ☐ TETRACYCLIN
- ☐ SULFA
- ☐ LOCAL ANESTHETIC
- ☐ FLUORIDE
- ☐ METALS (NICKEL, GOLD, SILVER, ETC.)
- ☐ PENICILLIN
- ☐ LATEX
- ☐ 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 and 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

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 lnformation").

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 lnformation"). Patients' Medical lnformation is collected and used for the purpose of diagnosing dental condition and providing dental treatment.

Patients' Medical lnformation 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.

lf 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 or dependant's information as set out above.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE: _____