OLIVERPARK DENTAL

PATIENT INFORMATION

Name (Last) _____ (First/Given) _____ (MI) _____

Preferred Name _____ **Gender** _____

Status ☐ Married ☐ Single ☐ Other ☐ Child

Birth Date _____ (Day/Month/Year) **Email Address** _____

Telephone _____ **Preferred Contact Method** ☐ Cell ☐ Email ☐ Text

Address (Unit#/Street name) _____

City/Prov. _____ **Postal Code** _____

Emergency Contact Information

Name _____ **Phone #** _____ **Relationship** _____

Whom may we thank for referring you to our practice?

☐ Family Name _____

☐ Friend Name _____

☐ Sign ☐ Website ☐ Social Media ☐ Flyer ☐ Other (Please Specify) _____

Primary Insurance

Employer _____

Name of Insured _____

Date of Birth (Insured/Plan Holder) _____ (DD/MM/YYYY)

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Plan Name (Insurance Company) _____

Group/Plan/Policy# _____ **ID/Certificate #** _____

Secondary Insurance

Employer _____

Name of Insured _____

Date of Birth (Insured/Plan Holder) _____ (DD/MM/YYYY)

Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Plan Name (Insurance Company) _____

Group/Plan/Policy# _____ **ID/Certificate #** _____

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E smile@oliverparkdental.ca

OLIVERPARK DENTAL

MEDICAL HISTORY Please check all that apply

Drug Allergy
- ☐ codeine
- ☐ ibuprofen
- ☐ penicillin
- ☐ sulfa
- ☐ erythromycin
- ☐ other _____

Cardiovascular/Heart
- ☐ angina
- ☐ anemia
- ☐ bypass surgery
- ☐ heart attack
- ☐ heart murmur
- ☐ low blood pressure
- ☐ high blood pressure
- ☐ heart disease
- ☐ blood disorder
- ☐ pacemaker
- ☐ rheumatic fever
- ☐ valve replacement

Nervous
- ☐ neurological disorder
- ☐ stroke
- ☐ mental health
- ☐ multiple sclerosis
- ☐ head injury
- ☐ epilepsy
- ☐ seizures
- ☐ Creutzfeldt-Jakob [prion]
- ☐ anxiety

Skin
- ☐ acne
- ☐ eczema
- ☐ basal cell carcinoma

Respiratory
- ☐ sinus
- ☐ tuberculosis
- ☐ asthma
- ☐ lung cancer

Bone
- ☐ arthritis
- ☐ osteoporosis
- ☐ joint replacement

Urinary
- ☐ kidney disease

Reproductive
- ☐ prostate cancer
- ☐ breast cancer
- ☐ ovarian cancer
- ☐ birth control

Marijuana Use
- ☐ recreational
- ☐ medicinal
- ☐ inhalation
- ☐ edible
- ☐ vape use

Other
- ☐ recreational drug use
- ☐ tobacco use
- ☐ vape use
- ☐ weight fluctuation
- ☐ chemotherapy
- ☐ sleep apnea
- ☐ insomnia
- ☐ steroid use
- ☐ radiation treatment
- ☐ celiac

Muscular
- ☐ muscular dystrophy

Digestive
- ☐ ulcers
- ☐ liver disease
- ☐ hepatitis [specify Type]

Endocrine
- ☐ thyroid disease
- ☐ diabetes [specify Type]

Immunodeficiency
- ☐ STI
- ☐ herpes [specify Type]
- ☐ super bugs MRSA/VRE
- ☐ HIV/AIDS

Please list all medications and/or supplements (prescription or non-prescription).

Name and Dosage.

Weight _____lbs **Height** _____ cm

Have you been hospitalized or undergone surgery in the past 2-3 years? ☐ Yes ☐ No

Have you ever taken antibiotic premedication for dental treatment? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due Date _____

Are you breast feeding? ☐ Yes ☐ No

Are you currently attempting to conceive? ☐ Yes ☐ No

When was your last medical examination? _____

Are you presently under the care of a physician? ☐ Yes ☐ No

If so, why? _____

Please provide the name, address and phone number of your primary physician

_____

OLIVERPARK DENTAL

DENTAL HISTORY

What is the reason for your dental visit today? _____

Please check all that apply.

☐ frequent headaches ☐ jaw/TMJ problems ☐ clenching/grinding ☐ orthodontics/braces ☐ sleep apnea
☐ receding gums

Do you currently have the following?

☐ oral device/appliance ☐ denture ☐ night guard ☐ sports guard ☐ orthodontic retainer
☐ other (specify) _____

How often do you brush your teeth?

☐ once/day ☐ twice/day ☐ 3 times/day ☐ seldom ☐ never

How often do you floss your teeth?

☐ once/day ☐ weekly ☐ seldom ☐ never

Do you have dental anxiety?

☐ yes ☐ no

Are you interested in sedation for dental treatment?

☐ yes ☐ no

Previous dentist's name, address, telephone number

When was your last visit to the dentist? _____

What was done at your last dental office? ☐ examination ☐ hygiene ☐ dental treatment

Authorization

To the best of my knowledge, all of the preceding information is true and correct. If there is a change to my health, I will inform the office at my next dental appointment without fail.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance.

Signature: _____ **Date:** _____

Relationship to Patient: ☐ self ☐ parent/guardian

Attending Dentist: _____ **Date:** _____

Dentist Signature: _____

PRIVACY INFORMATION POLICY

In compliance with the Federal Personal Information Protection of Electronic Document, Alberta's Personal Information Protection Act and the Health Information Act, Oliver Park Dental has created the following policy to ensure the privacy of our patients and staff are protected.

Privacy of your personal information is an essential part of providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly and strive to be as open as possible (with you) about the way we handle your information.

The personal information that we collect is necessary to provide you with appropriate care. This includes contact, medical and financial information. Once the information is collected, we ensure that it remains secure. We do not share your information outside of our office for any marketing, promotional, publicity, or research purposes without your specific consent.

Personal Information & Privacy Consent Form

• By signing this form, I agree that Oliver Park Dental can collect and disseminate my personal information on an ongoing basis [including contact, financial and relevant medical information] as required for the following reasons:
• To open and update patient files
• To provide appropriate dental treatment
• To invoice patients for dental services, to process payments or to collect unpaid accounts
• To process claims for reimbursement from third party health benefit providers and insurance companies
• To contact patients regarding the need for further examination, treatment or information
• To provide other dentists or dental specialists relevant information necessary for a second opinion or treatment
• To provide continuity of care in the event of practitioner change within Oliver Park Dental
• To allow for transfer of x-rays between professional offices (dentists, dental specialists)

Signature _____ **Date** _____

Relationship to Patient ☐ self ☐ parent/guardian

OLIVER PARK DENTAL PAYMENT POLICY

I The Administrative Team at OPD will submit a claim electronically to your private benefits provider (on your behalf) on the day of treatment. We will require a credit card on file if you wish to proceed with this option.

II Should we receive a breakdown of your coverage from your private benefits provider on the day of treatment (EOB- Explanation of Benefits), you will be required to pay any remaining balance indicated.

III If we do not receive the breakdown of your coverage (Claim Acknowledgement) –100% of the balance is due on the day of treatment, and you will be reimbursed by your benefits provider based on their rates and the specified parameters of your private plan.

IV We will accept dual insurance information. However, we are NOT able to direct bill to a secondary insurance policy. We will submit and direct bill to your primary insurance based on the above terms and you will be responsible to pay any differences on the date of service. We will then submit to your second insurance plan to reimburse you based on your coverage.

****You are encouraged to review your private benefits policy with your provider and/or plan administrator (if applicable) in detail. Due to confidentiality reasons and privacy laws, we are not privy to specific details of your plan.**

I, _____ authorize Oliver Park Dental to keep my signature on file and to process my credit card for any unpaid portion once the insurance payment has been received. I will be notified by telephone or email prior to Oliver Park Dental taking any payments
exceeding $150.

I give permission for any claim not paid by my insurance company within 30 days, to be automatically debited on my credit card. A courtesy call or email will be given to alert me of the transaction. A receipt for this transaction will also be provided.

Credit Card Information

Type (please circle) Visa Master Card

Card Number _____

Expiry Date _____

Signature _____

Date _____