Big Country Dental
394 1 Street E, PO Box 2730 Drumheller, AB T0J 0Y0 bigcountrydental@gmail.com

Patient Information:

Patient Name		Date of Birth		Gender:
Address:				
City/Town:		Postal Code:		
Home Phone:		Cell Phone:		
Email:		Emergency Contact Name:		
Alberta Health Care #		Emergency Contact Phone:		

Responsible Party Information *Complete if the person responsible for payment is NOT the named Patient.

Name:		Relationship to Patient:
Phone:		Email:

Dental Insurance Information:

Insurance Plan		Policy Holder Name:	
Policy/Group #		Policy Holder D.O.B.:	
ID/Certificate #		Policy Holder Gender:	
Policy Holder Address:			

Insurance Plan		Policy Holder Name:	
Policy/Group #		Policy Holder D.O.B.:	
ID/Certificate #		Policy Holder Gender:	
Policy Holder Address:			

<u>Financial Policy</u>

I authorize the collection and use of any information necessary for the purpose of my treatment and to process claims. I understand that my billing will be submitted to my insurance provider as a courtesy, and that any copayment for treatment that is not covered by my insurance will be due payable at the time of service.
By signing below I acknowledge I understand and will abide by this policy.

Signature of Patient/Guardian:_____ Date: _____

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Taking Care of You & Your Health Information

Big Country Dental respects your confidentiality and privacy.

When you receive health services from our Practice, we will collect individually identifying health information in accordance with the provisions of the Alberta Dental Association and the Health Information Act.

We will collect this health information directly from you, except in the limited circumstances where we are authorized under HIA to indirectly collect such information.

Our primary purpose in collecting your health information is to:

- Provide diagnostic treatment and care services to you
- Determine or verify your eligibility for health services
- Direct bill your insurance provider for our services

Our Practice will only collect, use and disclose your health information in accordance with the provisions of HIA.

All members of our Practice ensure strict compliance with the regulatory and ethical guidelines set by the Alberta Dental Association and the Health Information Act. We understand the importance of your privacy and personal information and will only collect what is necessary . We will collect, use and disclose your information in a responsible manner and in compliance with existing legislature and privacy protocols.

Consent for Dental Treatment

I will inform the dentist if there are any changes to my health or medication. I further consent to the performing of dental procedures agreed to be necessary or advisable, including the use of local anesthetic or any drugs as indicated.

Signature of Patient/Guardian: _____ Date: _____

Information & Privacy Consent

I acknowledge that I have been made aware of why I have been asked to consent to the disclosure of the above information, and am aware of the risks and benefits associated with consenting to the disclosure of my individually identifying health information. I understand that I can refuse my consent at any time in writing, but that in doing so it will result in the inability of Big Country Dental to provide me with proper oral care.

Signature of Patient/Guardian: _____ Date:_____

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Dental History

Are you satisfied with the appearance of your teeth and smile?	Yes:	No:
Do you have gum issues or sensitivity?	Yes:	No:
Do you brush and floss daily?	Yes:	No:
Do you notice popping/clicking or soreness in your jaw?	Yes:	No:
Do you grind or clench your teeth?	Yes:	No:
Have you ever had a difficult extraction?	Yes:	No:
Do you get cold sores?	Yes:	No:
Do you have difficulty with dental freezing?	Yes:	No:

When was your last dental visit? _____

When were your last x-rays taken and where? _____

On a scale of 1-10 how fearful are you of the dentist? _____

Dental History for Children

Please circle any applicable areas:

Does your child have any oral habits such as:

Thumb/finger sucking Grinding teeth Mouth breathing Chewing on items

Is there a family history of:

High tooth decay rate Tooth deformity Cleft Lip/Palate Gum disease

Has your child ever received any fluoride treatment?	Yes:	No:
Do you assist your child to brush their teeth:?	Yes:	No:
Does your child brush and floss daily?	Yes:	No:

Do you have any specific concerns: _____