WELCOME TO HARVEST DENTAL CARE

The following information is strictly confidential and will only be used according to the Personal Information Consent (in accordance with Canada's Anti-Spam Laws). Provided phone numbers and e-mail address will only be used to communicate between the reception staff at Harvest Dental Care and you, and not for any other purpose.

Please also complete these forms: NP2 **PERSONAL INFO. CONSENT** NP3 **OFFICE POLICY & PAYMENT OPTIONS**

A) REGISTRATION INFORMATION

1) PERSONAL INFORMATION (Please be prepared to provide Government Issued Photo Identification)

PATIENT NAME (LASTNAME, FIRSTNAME)	PREFERRED NAME (opt.)	PARENT NAME (if patient is child)

ADDRESS (including City/Town)	POST CODE	DATE OF BIRTH DAY MONTH YEAR	GENDER (CIRCLE) M F T U

CELL PHONE	HOME PHONE	WORK PHONE

E-MAIL ADDRESS (required)	OCCUPATION (optional)

HOW WOULD YOU LIKE US TO CONTACT YOU ABOUT UPCOMING APPOINTMENTS AND/OR REMINDERS?

☐ TEXT MESSAGES (TO YOUR MOBILE PHONE) ☐ E-MAIL MESSAGES
☐ CELL PHONE CALL ☐ HOME PHONE CALL ☐ WORK PHONE CALL

2) EMERGENCY CONTACT (Preferred contact in event of an emergency)

NAME	RELATIONSHIP	PHONE

3) HOW DID YOU FIND HARVEST DENTAL CARE? (optional, but appreciated)

☐ INTERNET SEARCH ☐ GOOGLE MAPS/REVIEW ☐ FACEBOOK ☐ INSTAGRAM
☐ ROAD/PLAZA SIGN ☐ BUS BENCH ☐ CLINIC REFERRAL

☐ FRIEND OR FAMILY
Please write their name: _____

☐ OTHER
Please state your reason: _____

B) INSURANCE INFORMATION

Please be advised that dental insurance or benefits are a contract between you, your employer and your insurance provider and any available benefits are determined by your individual policy. Under the Privacy Act, the majority of insurance providers will not provide our office with specific details regarding your coverage. We cannot affect how much of our fees your insurance will cover. Our objective as dental health care providers is to diagnose any treatment required specific to each patient's needs. We cannot be certain if your insurance will cover treatment, as this is only outlined in your master policy underwriting (sometimes summarized in a handbook). If you require assistance in understanding your handbook, we can examine it for you.

1) Do you have dental insurance benefits?
☐**NO** Insurance Plan ☐**ONE** Insurance Plan ☐**TWO OR MORE** Insurance Plans

2) Do you have insurance card(s) with policy detail(s)?
☐**NO** - Payment is required at time of treatment; We will submit paperwork for your provider to reimburse you.
☐**YES** - Kindly provide your insurance card(s) to reception to enter directly onto your profile.

3) If your insurance coverage is through a spouse or a family member, complete the section below:

INSURED FAMILY MEMBER NAME	FAMILY MEMBER DATE OF BIRTH DAY MONTH YEAR	RELATIONSHIP ☐SPOUSE ☐CHILD ☐OTHER

PATIENT NO. (OFFICE USE)

⇨ **PLEASE COMPLETE THE BACK SIDE OF THIS FORM**

HARVEST DENTAL CARE

C) MEDICAL HISTORY QUESTIONNAIRE

1. Are you currently being treated for a medical condition or have been hospitalized in the past?..... ☐YES ☐NO

Medical Condition:

Physician's Name:

2. Are you taking Medication or Herbal Products?... ☐YES ☐NO
If YES, please list below or provide Pharmacy Name & Location:

☐Will provide separate list
☐Steroids/Prednisone ☐Blood Thinners ☐Osteoporosis medications

3. Do you have Allergies?..... ☐YES ☐NO

☐Penicillin ☐Clindamycin ☐Sulfa drugs ☐Codeine (Tylenol #3)
☐ASA (Aspirin) ☐Ibuprofen (Advil or Motrin) ☐Tylenol (Acetaminophen) ☐Latex/Rubber
☐Metals ☐Foods ☐Other:

4. Do you have Heart Condition(s)?..... ☐YES ☐NO
☐Heart Attack in Past ☐Stroke in Past ☐Chest Pain/Angina
☐Mitral Valve Prolapse ☐Heart Murmur ☐Heart Defect at Birth
☐Infective Endocarditis Diagnosis Date:

5. Do you have Artificial Joint(s)?..... ☐YES ☐NO
☐Knee ☐Wrist Surgeon Name:
☐Hip ☐Elbow Surgery Date:

6. Do you have Breathing Problem(s)?..... ☐YES ☐NO
☐Asthma/Inhaler Use ☐Shortness of Breath ☐Lung Disease

7. Do you have Immune or Blood Problem(s)?..... ☐YES ☐NO
☐Hepatitis A/B ☐Hepatitis C ☐HIV/AIDS
☐Leukemia ☐Radiation Therapy ☐Chemotherapy
☐Prolonged Bleeding ☐Bleeding/Hemophilia ☐Cancer
☐Blood Clots ☐Anticoagulants ☐Diabetes

8. Do you have Stomach, Digestion or Kidney Problems?..... ☐YES ☐NO
☐Stomach Ulcers ☐Acid Reflux/Heartburn ☐Jaundice
☐Kidney disease ☐IBS, Crohn's, Colitis ☐C. Difficile

9. Do you have Thyroid Disease?..... ☐YES ☐NO
☐Hyperthyroidism ☐Hypothyroidism ☐Unsure which type

10. Do you have any of these Habits?..... ☐YES ☐NO
☐Tobacco Smoking ☐Cannabis Smoking ☐Chewing Tobacco
☐Alcohol Dependency ☐Street Drugs

11. Have you been in a Motor Vehicle Accident or Traumatic Injury?..... ☐YES ☐NO
☐Motor Vehicle Injury ☐Work Related Injury ☐Sports Related Injury
Date of Accident/Injury:

12. Women only: Do any of the following health statuses apply to you?..... ☐YES ☐NO
☐Pregnancy ☐Nursing/Breastfeeding ☐Birth Control

D) DENTAL HISTORY QUESTIONNAIRE

1. What is the main purpose of your visit to Harvest Dental Care today?.....
☐Professional Cleaning ☐Check-up ☐Emergency
☐Consultation (e.g. Invisalign)) ☐Cosmetic (e.g. Botox) ☐Second Opinion

2. When was your last Dental Cleaning?
☐Under 12 months
☐Between 1-3 Years
☐Over 3 Years

3. Have you had Dental X-Rays in the last 12 months?..... ☐YES ☐MAYBE ☐NO

4. Have you received any of the following types of dental treatment?.....
(please check mark all of those that apply)
☐Orthodontics
☐Root Canals
☐Crowns/Bridges
☐Dentures
☐Dental Implants
☐Oral Surgery

5. Has a doctor ever advised you to take antibiotics prior to a dental visit?..... ☐YES ☐SOMETIMES ☐NO

6. Do your gums bleed when you brush your teeth?..... ☐YES ☐SOMETIMES ☐NO

7. Are you nervous about receiving dental treatment?.....
☐YES, Very Nervous
☐YES, Little Nervous
☐NO, I'm Calm

8 Do you clench/grind your teeth or diagnosed with a TMJ disorder?..... ☐YES ☐NO ☐Have Nightguard

9. Do you have frequent headaches?.....
☐YES, Everyday
☐YES, 1-3 Times/Week
☐YES, 1-3 Times/Month
☐NO, Infrequent

10. Do you have sore to chew, aching or sensitive teeth?..... ☐YES ☐NO

ALL HEALTH INFORMATION IS STRICTLY CONFIDENTIAL. The following information is required to enable the Harvest Dental Care staff to provide you with the best possible dental care.

To the best of my knowledge, the above information is correct. I consent to the dental procedures agreed to be necessary or advisable, including the use of local anesthetics or other medications as indicated, and I will assume responsibility for fees associated with those procedures.

TODAY'S DATE:

PATIENT NAME
(PLEASE PRINT):

SIGNATURE:
(PATIENT/PARENT/GUARDIAN)

THIS SECTION FOR OFFICE USE:

PATIENT NUMBER

☐ G.I.P.I. Checked ☐ M.H. Review
☐ Insurance Cards Staff Initials:

HARVEST DENTAL CARE

FAMILY & GENERAL DENTISTRY

PERSONAL INFORMATION CONSENT

We are committed to protecting the privacy of our patients' personal information and to 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.

We collect information from our patients such as provided names, home addresses, telephone numbers (home, work and cellular/text messaging) and e-mail addresses (collectively referred to as "Contact Information"). Contact Information is collected and consented for use (in accordance with Canada's Anti-Spam Legislation (CASL) in electronic communication) for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, process credit card payments, or collect unpaid accounts.
- To process claims for payment, reimbursement or pre-determination from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further dental examinations 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.

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

Dental information may include x-rays, photos, cast models, slides and/or videos. These will be used as a record of my care and may used for educational purposes in study club meetings, lectures, seminars, demonstrations, and professional publications (journals, magazines). I further understand that if the photographs, slides and/or videos are used in any publication or as part of a demonstration, the patient's name and other identifying information will be kept confidential. 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.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion and/or if the patient, with their consent, has been referred by us to the other dentist or dental specialists for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- 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 or if there are concerns with the patient's medical history, current medical treatment or otherwise.
- www.harvestdental.ca and any electronic submissions through this site allow us access to personal information such as, email addresses, IP addresses, names, phone numbers and dental requirements. Website information is collected and used for the purpose of booking/revising appointments.

If information is no longer required, all pertinent documents are destroyed using an on-site, secure document destruction program developed specifically to deal with regulatory privacy and confidentiality requirements. If we are 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 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 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 to Harvest Dental Care and/or Harvest Dental Care on Bow St.**

Your Name: Signature: Date:

PATIENT NO. (OFFICE USE)

Updated: Jan 2022

NP2

HARVEST DENTAL CARE

FAMILY & GENERAL DENTISTRY

OFFICE POLICY & PAYMENT OPTIONS

We value our relationship with you and believe that the best relationships are based on understanding. If you have any questions or concerns, please feel free to ask any member of our staff.

PAYMENT OPTIONS (PLEASE CHECK ONE)

- ☐ **No Insurance** - Full payment is required on the day when treatment is rendered.
- ☐ **One Insurance Plan** - If we receive an electronic explanation of benefits from your insurance provider, we will only require payment of the outstanding balance. If an electronic acknowledgement is not provided by your insurance provider, we will require a **minimum of 25% payment** of the treatment fees. If an outstanding balance remains after insurance payment is received or after 60 days from treatment, we will process the balance on your credit card (if available) or send you an account statement.
- ☐ **Two or More Insurance Plans** - We will process claims to your insurance companies, on your behalf, either electronically and/or manually. If an outstanding balance remains after insurance payment is received or 60 days following treatment, we will process the outstanding balance on your credit card (if available) or send you an mailed account statement.

Payment is due for all treatment completed on the day the service is rendered. We accept debit card (preferred), credit card and cash as payments. Personal cheques are not accepted. Any mailed account statements are subject to a $5 processing fee (this fee can be avoided by providing your credit card information, to be kept on file, to process outstanding balances). Alternatively, you can request to pay your entire treatment (to collect credit card reward points) and have your insurance provider(s) reimburse you directly – we will help complete insurance claim forms on your behalf.

OFFICE POLICY

- **Late or Missed Appointments** - Time booked for your appointment has been reserved for you. A charge of **$75.00** will be applied for each missed appointment if less than **one (1) full business day** notice is given to cancel an appointment.
- **Major Dental Treatment** - We require a **50% deposit** for major treatment (crowns, bridges, dental implants, night guards, snore guards and dentures). If we have a valid pre-authorization of benefits from your insurance provider, we will only require payment of the outstanding deposit amount. Any remaining balances are due on the day the treatment is completed.
- **Dental Insurance Coverage** - Under the Privacy Act, we have limited access to information from your insurance company regarding the details of your dental insurance plan. It is your responsibility to find out the specific details of your dental coverage.

By signing below, you agree with the office policy terms and payment options on this page and additionally agree to pay for services to Harvest Dental Care and/or Harvest Dental Care on Bow St in accordance with these terms.

Your Name: Signature: Date:

PATIENT NO. (OFFICE USE)

HARVEST DENTAL CARE

FAMILY & GENERAL DENTISTRY

PATIENT RELEASE OF DENTAL X-RAYS & RECORDS

Patient Name(s):	Patient Phone No:
Previous Dentist Name: (or Clinic Name)	
Previous Dentist Phone Number: (if available)	
Patient Signature: (or Guardian Signature)	Date:

The patient(s) listed above hereby authorize (signature above) the release of the following dental records from their respective chart(s) to Harvest Dental Care. Kindly notify us if the patient(s) listed above have not attended care at your office or if records requested are unavailable. Requested records are marked below:

- ☒ Panorex radiographs taken within last 5 years
- ☒ Periapical & Bitewing radiographs taken within last 2 years
- ☐ Probing depths scores taken within the last 2 years
- ☐ Dental reports (specialist or lab) provided within the last 2 years
- ☐ Chart notes noted in the past 5 years

By signing below, I agree to have my records transmitted by non-PIPEDA* compliant email (I understand that email is not a private mode of communication and that my dental records may be intercepted by someone other than the intended recipient). *PIPEDA = Personal Information Protection and Electronic Documents Act.

NOTES FOR PREVIOUS DENTAL CLINIC

⚠ Kindly indicate the dates that x-rays/images were taken

E-MAIL: Digital radiographs as JPG/BMP/GIF or as PDF records. Email address indicated below.
FAX: Paper records. Fax number indicated below.
POSTAL MAIL: Film duplicates or any other duplicated records (If there are any duplication or forwarding costs involved, please contact our office before duplicating or sending). Clinic address indicated below.

Please phone us if you have any questions or concerns about sending records.

CALGARY DENTAL CLINIC
403 - 9650 Harvest Hills Blvd N.E.
Calgary, Alberta T3K 0B3
Tel: 403-226-2588
Fax: 403-263-2587
Email: info@harvestdental.ca

COCHRANE DENTAL CLINIC
#3 - 45 Bow Street
Cochrane, Alberta T4C 0T4
Tel: 403-981-2588
Fax: 403-981-0288
Email: cochrane@harvestdental.ca

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