LifePath Dental & Wellness

Unit 106, 175 Chestermere Station Way, Chestermere, AB T1X 0A4
Ph: 403-235-6208 Email: Chestermere@lifepathwellness.com

Confidential Patient Information

Name: ______________________ AHC# ______________

Birthdate ______________________ Age ________ Gender ○ Male ○ Female

Address ______________________

City/Prov ______________________ Postal Code ______________

Home Ph ______________ Work Ph ______________ Cell Ph ______________ Best Ph# to Confirm Appts ○ Hm ○ Wk ○ Cell

Email Address ______________ Employer ______________ Occupation ______________

Emergency Contact Name ______________ Relation ______________ Phone ______________

Whom may we thank for your referral? ○ The Anchor ○ Strathmore Standard ○ Walkby/or Area ○ Phone Book/Yellow Pages

○ Friend/Coworker ______________ ○ Family Member ______________

Please check all that apply to you:

○	HIV or AIDS	○	Diabetes (Insulin ○ Yes ○ No)	○	STD/Venereal Disease	○	Rheumatic Fever
○	Alcohol or Drug Abuse	○	Dizziness/Fainting	○	Jaundice	○	Sinus Problems
○	Anemia	○	Excessive Bleeding	○	Kidney Disease	○	Smoker
○	Arthritis	○	Glaucoma	○	Liver Disease	○	Ulcers
○	Artificial Valves/Joints/Pins	○	Growths or Tumors	○	Low Blood Pressure	○	Stomach Problems
○	Asthma (Inhaler ○ Yes ○ No)	○	Hay Fever	○	Pacemaker	○	Stroke (When ____________)
○	Blood Disorder/Transfusion	○	Head Injuries	○	Mental or Nervous Disorders	○	TMJ Problems
○	High Blood Pressure	○	Heart Disease	○	Tuberculosis	○	Epilepsy
○	Cancer/Chemo	○	Heart Murmer	○	Radiation Treatment	○	Other (________________)
○	Congestive Heart Failure	○	Hepatitis (Type ________)	○	Respiratory Problems		

IMPORTANT: Do you require PREMEDICATION (ANTIBIOTIC COVERAGE) for dental treatment? (i.e.: Heart valve problems, heart disorders, artificial hip, etc…) ○ Yes ○ No

Do you have ALLERGIES to?

○	Aspirin	○	Codeine	○	Erytyhromycin	○	Local Anesthetic (Freezing)
○	Penicillin	○	Sulpha	○	Latex	○	Other (________________)

Have you ever had a reaction to any drug or medication? ○ Yes ○ No explain ______________

Family Doctor: ______________ Phone: ______________

Have you been under the care of a physician recently? ○ Yes ○ No explain ______________

Have you been admitted to a hospital in the last 2 years? ○ Yes ○ No explain ______________

List all medications, pills, vitamins or herbs you are presently taking: ______________

Dental Information

Previous Dental Office & Dentist's Name: ______________ Last visit: ______________ What was done? ______________

Reason for this visit? ______________

Are you currently in any discomfort or pain with your teeth or gums? ○ Yes ○ No Explain: ______________

How would you describe the current condition of your oral health? ○ Poor ○ Fair ○ Excellent

Are you nervous or anxious during dental treatment? ○ Yes ○ No

Have you ever fainted or had complications following dental treatment? ○ Yes ○ No

Have you ever had an injury, surgery or x-ray therapy to the face or jaw? ○ Yes ○ No

Are you happy with your smile? ○ Yes ○ No

Do your gums ever bleed? ○ Yes ○ No

Would you like to have whiter teeth? ○ Yes ○ No

Do you clench or grind your teeth? ○ Yes ○ No

What would you change? ______________

Are you unhappy with any silver or discolored fillings? ○ Yes ○ No

Would you like to have straighter teeth? ○ Yes ○ No

Do you have pain in your jaw? ○ Yes ○ No

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Our Appointment Policy

Thank you for allowing us the privilege of being your Dental Health provider. Our practice is dedicated to quality care and is pleased to reserve time exclusively for each patient.

We respect our patients' time and make every effort to remain on schedule. Despite careful scheduling, dental emergencies can cause delays. If your appointment time is affected due to an unforeseen emergency, we will try our best to notify you in advance. We know that your time, like our Doctor's, is valuable and we will make every effort to see you on time and will ensure you are given the same time and attention for your dental health.

Because we reserve time exclusively for you, we ask that you make every effort to keep your reserved appointment time. If you find that you cannot keep your scheduled visit, **we require a minimum of 2 business day's notification.** Advance notice allows our office to see other patients who may have been waiting to see us for needed treatment. We thank you in advance for your consideration. **A charge of $75.00 may apply to your account if sufficient notice is not provided; this charge is at the discretion of your Doctor.**

Financial Policies For Patients with Dental Insurance

(IMPORTANT: Please read and initial if you request direct billing to your Insurance, if you wish to pay in full for your dental treatment and be reimbursed by your dental plan, please omit this portion.)

Many of our patients have dental insurance. While your dental insurance policy is an agreement between you and your insurance company, we will be happy to assist you in preparing and sending in the necessary forms. Please remember that no insurance company attempts to cover all dental costs. We cannot render dental treatment on the assumption that our charges will be paid in full by an Insurance Company. Full payment to our office remains your responsibility, regardless of how much your insurance does or does not pay. (Please see the attached information on dental insurance for more information.)

I am aware that Lifepath Dental direct bills my Insurance Company as a courtesy to me and that in doing so, the dental office accepts no responsibility for any uncovered amounts, amounts over benefit maximums, limitations or plan restrictions, etc. I understand that the dental office collects my dental coverage information as a guideline ONLY to assist me in maximizing my benefits this does not hold them responsible for my dental account. Lifepath Wellness advises that I make myself very aware of my dental plan, knowing my coverage and that I ask my dental team about any and all procedures I am authorizing.

Please email/bring in dental plan breakdown (available online through your insurance provider) to chestermere@lifepathwellness.com. Lifepath Wellness advises me to contact my plan administrator or Insurance Company for questions regarding eligible procedures and authorization of treatment. And to make myself aware of all costs involved with my dental care. Lifepath advises me to keep track of my yearly maximums, limitations, appointment dates, and accumulated amounts used on my dental benefit plan. _____ initial

Payment is due at the time of service. I am aware that if the dental office does not receive confirmation from my Insurance for their exact payment—Lifepath Dental will estimate my portion only at the time of visit. Any unforeseen balances will then be informed to me by statement. I agree to pay all of these uncovered portions within 10 days from the date of statement or interest charges of 6% per month may be applied to my account. I agree to pay these interest charges if applied to my overdue account. _____ initial

I also understand that any uncovered procedures that may have been done at another Dental office are my responsibility. IMPORTANT: Please be advised that complete oral examinations (new patient exams) & x-rays will be denied by your insurance if you have had this procedure at another dental office within the time limitations on your specific plan. You are responsible for this procedure in our office should this not be an eligible benefit with your coverage. ______initial

I am aware that NSF fees (returned cheques) are $50 for every returned personal cheque. _____ initial

Consent for Treatment/Accountability Confirmation

To the best of my knowledge all of the preceding answers and information provided are true, complete and accurate. I grant permission to you and your assignees to telephone me to discuss matters related to this form. I understand that this information is held in the strictest confidence and it is my responsibility to inform the office of any changes to my medical status. I authorize the dental office to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

I, the undersigned, clearly understand all policies of Lifepath Wellness Centre. I understand and agree to pay all fees associated with my dental treatment. With or without Dental coverage, I agree to make myself aware of those fees prior to any dental treatment I authorize to be done.

______________________ Signature of Patient/Guardian

______________ Date

______________________ Printed Name

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Dental Office Personal Information Consent Form – Privacy Act Information

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 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 names, home addresses, work addresses, home telephone numbers, work telephone numbers and e-mail addresses. (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 for dental services, to process credit card payments, or to collect unpaid accounts
- To process claims for payment or reimbursement from third party health benefit providers and insurance companies
- To send reminders to patients concerning the need for further dental examination or treatment
- To send patients informational material about our dental materials
- To follow up with treatment and/or customer services

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 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 conditions and providing dental treatment.

Patients' Medical Information is disclosed for the following purposes:

- 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
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist 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, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment

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 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 our staff as part of its regulatory activities in the public interest.

______________________________ ______________________________

Signature **Today's Date**

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Your Dental Plan Information

Do you have insurance? ◯ Yes ◯ No

Primary Plan – (For children, the plan for the parent whose birth month comes first in the year is Primary plan)

Group# ______________________ Insurance Company: ______________________

ID or Certificate #: ______________________ Employer/Company Name: ______________________

Subscriber/Policy Holder's name: ______________________ Subscriber Date of Birth: ______________________

Will this plan allow payment to the Dentist? ◯ Yes ◯ No
(If your plan will not pay the Dentist directly, you are responsible to pay in full for your treatment on the date of service.)

Basic % of Coverage: ________ Major % of Coverage: ________ Orthodontic % of Coverage: ________

Maximum for Basic: ________ Maximum for Major: ________ OR Combined Basic & Major Max: ________

Do you have secondary insurance? ◯ Yes ◯ No

Secondary Plan

Insurance Company: ______________________ Group #: ______________________

ID or Certificate #: ______________________ Employer/Company Name: ______________________

Subscriber/Policy Holder's name: ______________________ Subscriber Date of Birth: ______________________

Will this plan allow payment to the Dentist? ◯ Yes ◯ No
(If your plan will not pay the Dentist directly, you are responsible to pay in full for your treatment on the date of service.)

Basic % of Coverage: ________ Major % of Coverage: ________ Orthodontic % of Coverage: ________

Maximum for Basic: ________ Maximum for Major: ________ OR Combined Basic & Major Max: ________

**PLEASE PROVIDE YOUR BENEFIT BOOKLETS BY PAPER COPY
OR PDF EMAILED TO CHESTERMERE@LIFEPATHWELLNESS.COM**

Your Dental Insurance

Many of us have dental plans available to us through our employers. These dental prepayment plans are referred to as "dental insurance" but they are not really insurance. They are a prepayment of benefits for a portion of the fees for dental services. More often than not, we do not know the specifics of these plans and we assume that the details are cut and dry.

One very important thing to note here is that not all dental plans are the same. You should be aware that dental plans are actually a way whereby your employer prepays all or a portion of the costs of your dental care in advance, as part of your compensation package. It is also important to remember that dental plan coverage is not a form of insurance.

Dental Fees and Your Dental Plan

Alberta dentists have always been able to set their own fees, for the services they provide, based on their individual practice situation.
The Alberta Dental Association and College has also provided practice management information and courses to dentists, to help them in determining costs and how to set fees. These fees are to be based on an individual dentists review of cost factors, such as the time needed to provide a service, the value of that service to the patient and the overhead costs of staff, materials, rent, loans, bank financing, insurance, and utilities among others. The fee should not be based on whether or not the patient has a dental plan, insurance or what fee the carrier of the dental plan will pay.
Decisions on dental plans are usually made during meetings with employers or plan sponsors and employees. Dental plan carriers use different means, such as the ADA&C's Annual Survey of Dental Fees in Alberta, in setting the level of payment of covered services. Some plan carriers are still not paying their clients the updated level of fees based on the current "Survey of dental Fees in Alberta".

Try to get as much data as you can from your company or organization's plan administrator or carrier before visiting the dentist. As there are dozens of companies selling dental plans, you cannot expect dentists and dental office staff to know about your plan and the coverage that you carry. Dental offices are not agents or brokers for any dental plan carrier.

If you have concerns with the level of payment or coverage your dental plan carrier is giving you for services you should inform your human resource officer, union leader or employer. These are the people who work out the dental contract with your carrier and they may not be fully aware of your concerns. It is unlikely that any dental plan would cover every service that you may need. But to leave the choice of your dental treatment to only what is covered in your dental plan, rather than what you and your dentist feel is appropriate, leaves your dental health and general well being in the hands of your plan carrier instead of you and your dentist.

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Patient Records Request Form

Patient Name: ____ Patient Date of Birth: __________________________________

This letter authorizes _________________________________ to release a complete set of records, including my x-rays, chart notes and all

other records or those of my minor child ________________ to Chestermere Lifepath Wellness, Ltd. located at the above-noted address.

I represent that I have legal authority to authorize the release of records requested. I understand that the information in my/my minor child's health record may include, but is not limited to, information related to my/my minor child's physical, behavioral, or mental health conditions previously disclosed.

If you have questions about the disclosure of the requested records, please contact Chestermere Lifepath Wellness, Ltd. at (403) 235-6208.

This request is for my minor child? ◯ Yes ◯ No

Name of Child ____

Name of Parent on behalf of minor Patient ______________________________________

Name of Patient ____

____________________________________ ______________________________

Signature of Patient/Parent/Guardian Date

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Payment Options

Thank you for choosing LifePath Dental & Wellness

LifePath Dental & Wellness is please to offer you the following payment options.

◯ ***Option 1:*** Payment is due in full the day treatment is rendered. We accept cash, cheque, debit, Visa, MasterCard, American Express, and E-transfers (accounts@lifepathwellness.com

◯ ***Option 2:*** Your insurance company may require you to, or you may prefer to, pay for your dental work directly on your treatment day and have your insurance company reimburse you. LifePath Dental & Wellness will process your payment on the date treatment is rendered. Our Team Members will assist you in submitting the necessary documents to your insurance carrier.

◯ ***Option 3:*** You may leave your credit card number on file, and we will directly bill your insurance company; you do not have to wait around on your treatment day. Once your insurance company has paid us their portion, our Financial Advisors will process portion to the credit card on file and email you your receipts. **LifePath Dental & Wellness** will provide estimates when requested.

I, ______________________________________, have ***Option 3***, and I hereby authorize any balances not covered by my insurance to automatically be applied to my credit card.

I, ______________________________________, have chosen ***Option 3***, for the following family members and I hereby authorize any balances not covered by my insurance to automatically be applied to my credit card.

____
print name(s)

____ __________________________
Signature Date