New Patient Intake

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

Name: _____ Date of Birth: _____ A.H.C. #: _____

Home Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact Name: _____ Cell phone: _____

If Patient is a minor, name of parent / guardian: _____ Phone (if different from above):_____

Current Dentist: _____

If you were not referred to us by your current dentist, how did you hear about us: ☐ Word of mouth ☐ Drive/Walk By ☐ Newspaper

☐ Facebook ☐ Internet search ☐ Website ☐ Family / Friend ☐ Other_____

Medical Physician: _____ Are you presently being treated by a physician? _____

Are you taking any medications now? _____ If yes, please list: _____

_____

Do you have any allergies (medications/drugs/food): _____ If yes, please list: _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma or Hay Fever
- ☐ Blood Disease
- ☐ Bone Disease
- ☐ Cancer - Type: _____
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Heart Ailments
- ☐ Heart Murmur
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Immune Disorder
- ☐ Joint Replacement
- ☐ Pacemaker
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever or Rheumatic Heart Disease
- ☐ Seizures
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Surgery - When: _____
- ☐ Tumors or Growths
- ☐ Other:

Women: Are you pregnant? _____ ***Please inform our office if you become pregnant prior to or during the course of treatment.***

PRESENT SYMPTOMS:

- ☐ None
- ☐ Heat
- ☐ Cold
- ☐ Sweet
- ☐ Relieved by Cold
- ☐ Apical Palpation
- ☐ Pressure
- ☐ Unstimulated/Spontaneous
- ☐ Swelling
- ☐ Acute
- ☐ Moderate
- ☐ Mild
- ☐ Constant
- ☐ Intermittent
- ☐ Interferes with Sleep
- ☐ Interferes with Eating
- ☐ Needs Pain Medication
- ☐ Is there any relief and what helps? _____

Are you taking any pain medication? _____ If yes, please list: _____

- **To the best of my knowledge all 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 or dental history.**

_____ _____ _____

Signature *Date* *Printed Name*

OUR APPOINTMENT POLICY

Thank you for allowing Lifepath Wellness the privilege of being your dental health provider. 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 do our best to notify you in advance, and we will make every effort to seat you on time and ensure you are given the attention required to address your dental needs.

Because we reserve time exclusively for you, we ask that you respect our commitment to you and our other valued patients. Please 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 days' notification**. Advance notice allows our office to see other patients who may be on a waiting list 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.***

_____ *initial*

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 disregard this section.)

Many patients have dental insurance, and we are happy to assist them prepare and submit the necessary insurance forms. Please note that no dental insurance plan covers all dental costs. We cannot render dental treatment on the assumption that our charges will be paid in full by an insurance company. Accordingly, full payment for dental services remains your responsibility regardless of the charges your insurance covers. Please review and acknowledge the following paragraphs as they apply to you as a patient or parent of a minor patient, and see the following information on dental insurance for more information regarding coverage.

I am aware that Lifepath Wellness direct-bills my Insurance Company as a courtesy to me, and that in doing so, Lifepath Wellness accepts no responsibility for any uncovered charges, including, but not limited to costs and fees over and above benefit maximums, coverage limitations or plan restrictions. I understand that Lifepath Wellness collects my dental coverage information *as a guideline only* to assist me in maximizing my benefits. I acknowledge that by doing so, Lifepath Wellness is not responsible for my dental insurance account. Lifepath Wellness has advised me to make myself aware of my dental plan coverages and to ask my dental team about any and all procedures I am authorizing. _____ *initial*

Lifepath Wellness has advised me to contact my plan administrator or insurance company for questions regarding eligible procedures and authorization(s) for specific treatment. In addition, I acknowledge that it is my responsibility to make myself aware of all costs involved with my dental care, as well as 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 understand that if Lifepath Wellness does not receive confirmation from my insurance carrier for the precise coverage amount, Lifepath Wellness will *estimate* my patient portion of the balance owed for treatment at the time of my visit, which I agree to pay within **10 days** from the date of the issued statement. I understand and agree that any unpaid balances after 10 days shall be subject to interest charges of 5% per month until paid in full. I agree to pay these interest charges if applied to my overdue account. _____ *initial*

Furthermore, I understand that any uncovered procedures that may have been performed at another dental office are my sole responsibility. IMPORTANT: Please be advised that complete oral examinations (new patient exams) & x-rays will be denied by your insurance carrier if you have had this procedure performed at another dental office within the time limitations set forth in your specific insurance plan. You agree that you are responsible for all charges for these procedures and x-rays in our office should they not be an eligible benefit under your coverage. _____ *initial*

I agree to pay a service charge of $50 to Lifepath Wellness for any returned cheques resulting from insufficient funds in my bank account. _____ *initial*

ACCOUNTABILITY CONFIRMATION

I, the undersigned, understand and agree to be bound to the foregoing policies of Lifepath Wellness. I understand and agree to pay all fees associated with my dental treatment, including any collection costs and fees incurred associated with collection of outstanding balances, and I agree that it is my responsibility to make myself aware of costs for dental treatment prior to any dental treatment.

_____	_____	_____
Signature	*Date*	*Printed Name*

DENTAL OFFICE PERSONAL INFORMATION CONSENT

Privacy Act Information

We are committed to protecting the privacy of our patients' personal information and utilizing all personal information in a legal, 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, dates of birth, social insurance numbers, home addresses, work addresses, 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 products and services
- 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.

A Patient's Medical Information may be disclosed to the following:

- 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.
- To third parties pursuant to a valid written authorization by the patient or to third parties pursuant to court order.

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. In addition, if we consider 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 and maintains confidentiality of Medical Information as set forth herein.

I have read and agree to the foregoing terms.

_____ _____

Signature *Date*

INSURANCE INFORMATION

Insurance Information *(please provide your insurance card for us to copy and keep on file)*

If your plan does not allow direct payment to the Dentist, you are responsible to pay for your treatment in full on the date of service.

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

Insurance Company: _____ *Group #:* _____

ID or Certificate #: _____ *Employer/Company Name:* _____

Subscriber/Policy Holder's name: _____ *Subscriber Date of Birth:* _____

Secondary Plan

Insurance Company: _____ *Group #:* _____

ID or Certificate #: _____*Employer/Company Name:* _____

Subscriber/Policy Holder's name: _____ *Subscriber Date of Birth:* _____

YOUR DENTAL INSURANCE

Canadian Dental Association / L'Association dentaire canadienne

Many patients possess employer-sponsored dental prepayment plans, often referred to as "dental insurance." These plans are not considered insurance in the traditional sense. Instead, these plans cover a portion of the fees for dental services utilizing prepaid benefits, which are traditionally part of your compensation plan. We are not privy to the specifics of each of these plans, and not all dental plans are the same.

Alberta dentists set their own fees for services. 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. The fees set by dentists are based on a number of factors, including the time and complexity of the services provided, provincial requirements for maintenance and sterilization, the value of that service to the patient, and overhead costs of staff, materials, rent, loans, bank financing, insurance, continuing education, and utilities among others. Fees are not based upon availability of a dental plan, insurance or what coverage is available for specific services.

Your health and well-being is our concern. Our providers make treatment recommendations based upon your individual needs and health requirements. We do not base our treatment plans or recommendations upon the level of insurance available to you. However, it is your responsibility to know what coverage is available to you. You can obtain coverage information directly from your company or organization's plan administrator or insurance carrier before visiting the dentist. If you have concerns regarding your dental plan or insurance coverage, contact your employer's human resources department, union leader or employer for details. It is unlikely that any dental plan would cover every service that you may need.