Discover Dental

CALL US AT : 403.285.0222

Patient Information:

First Name | Middle Name | Last Name

Street Address | City/Town | Postal Code

Date of Birth (D/M/Y) | Driver's License #

E-Mail Address | Home Phone Number

Work Phone Number | Cell Phone Number

Emergency Contact Name | Emergency Contact Phone Number

How did you find out about Discover Dental?

Dental History

What is your immediate concern?

How would you rate the condition of your mouth? ○ Excellent ○ Good ○ Fair ○ Poor

Are you fearful of dental treatment? ○ Yes ○ No

Scale of 1 (none) to 10 (very): _____

Have you ever had an unfavorable dental experience? ○ Yes ○ No

Details _____

Have you ever had trouble getting numb or reactions from local an anesthetic?	○ Yes ○ No
Did you ever have braces, orthodontic treatment or had your bite adjusted?	○ Yes ○ No
Do you /would you have any problem chewing gum?	○ Yes ○ No
Do you/would you have any problem chewing bagels or other hard foods?	○ Yes ○ No
Have your teeth changed in the last 5 years, become shorter, thinner or worn?	○ Yes ○ No
Are your teeth crowding or developing spaces?	○ Yes ○ No
Do you have any problems with sleep or wake up with an awareness of your teeth?	○ Yes ○ No
Any problems with your jaw joint? (Pain, Sound, Limited opening, Locking, popping)	○ Yes ○ No
Do you have tension headaches or sore teeth?	○ Yes ○ No
Do you wear or have you ever worn a bite appliance?	○ Yes ○ No
Are any teeth sensitive to hot, cold, biting or sweets?	○ Yes ○ No
Have you ever been diagnosed or treated for periodontal (gum) disease?	○ Yes ○ No
Have you experienced gum recession?	○ Yes ○ No
Do your gums bleed when brushing, flossing or eating?	○ Yes ○ No
Are your teeth becoming loose?	○ Yes ○ No
Have you ever noticed an unpleasant taste or odor in your mouth?	○ Yes ○ No

Medical History

Name of Physician and their speciality: _____

Date of last medical examination: _____

Purpose: _____

What is your estimate of your general health? ○ Excellent ○ Good ○ Fair ○ Poor

Do you have or have you ever had any of the following: Yes or No

Glaucoma	○ Yes ○ No	Osteoporosis/Osteopenia (i.e. taking bisphosphonates)	○ Yes ○ No
Heart problems	○ Yes ○ No	Alcohol/Drug dependency	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Artificial Prosthesis (i.e. Heart valve or joints)	○ Yes ○ No
Rheumatic Fever	○ Yes ○ No	Tuberculosis	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Breathing or sleeping problems (snoring, sinus)	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Liver Disease	○ Yes ○ No
HIV/AIDS	○ Yes ○ No	Arthritis	○ Yes ○ No
Tumor/Abnormal Growth	○ Yes ○ No	Contact Lenses	○ Yes ○ No
Radiation Therapy	○ Yes ○ No	Head or Neck Injuries	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Epilepsy, Convulsions (Seizures)	○ Yes ○ No
Venereal Disease	○ Yes ○ No	Neurologic Problems	○ Yes ○ No
Are you taking blood thinners?	○ Yes ○ No	Stroke	○ Yes ○ No
Hepatitis (type _____)	○ Yes ○ No	Viral Infections and Cold Sores	○ Yes ○ No
Antidepressant Medication	○ Yes ○ No	Any Lumps or Swelling in the Mouth	○ Yes ○ No
Anemia or Blood Disorder	○ Yes ○ No	Hives, Skin Rash, Hay Fever	○ Yes ○ No
Emphysema	○ Yes ○ No	Kidney Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Thyroid or Parathyroid Disease	○ Yes ○ No
Hormone Deficiency	○ Yes ○ No	Jaundice	○ Yes ○ No
Diabetes	○ Yes ○ No	High Cholesterol	○ Yes ○ No
Digestive Disorder (i.e. gastic reflux)	○ Yes ○ No	Stomach or Duodenal Ulcer	○ Yes ○ No
Are you presently being treated for any other illness?	○ Yes ○ No	(FEMALE) Are you taking birth control pills?	○ Yes ○ No
Are you subject to frequent headaches?	○ Yes ○ No	(FEMALE) Are you pregnant?	○ Yes ○ No
Are you a smoker or smoked previously?	○ Yes ○ No		

Are you allergic or ever had an allergic reaction to:

- ☐ Asperin, Ibuprofen, Acetaminophen
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Fluoride
- ☐ Metals
- ☐ Latex
- ☐ Penicillin
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Any other Medications

Please list any medication, vitamins, herbal or dietary supplements currently taking and what it is for:

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: _____

Date: _____

Discover Dental

Dr.Shazia Butt & Associates

Financial and Cancellation Policies

We are happy to assist you to understand your insurance benefits coverage. However, please know that your insurance policy is an agreement between you, your employer and the insurance company that provides your benefits. Not all services may be covered by your insurance and any fees not covered are the patient's responsibility. Every insurance plan has its own unique limitations, way of coordinating benefits, exceptions and fee schedules, therefore it is the Patients responsibilities to understand and advise our office of the limits and details of your insurance coverage. We cannot guarantee your individual coverage. All amounts billed for services rendered are ultimately the patient/account holders responsibilities to pay in full. Due to the Privacy Act, insurance companies will not discuss your coverage with dental offices.

Please note: There may be a difference in fee guides between our fees and your insurance companies fee guide. You are fully responsible to pay this difference and under no circumstances will we waive this amount.

As a courtesy we will direct bill your insurance company, if your plan allows. To do so we require a credit card placed on file. Patient portions are due at the time of service. Any amount not covered by your insurance within 45days becomes your responsibility. We will automatically bill your credit card for any amount under $200 and mail you a receipt.

VISA/MC # _____

Expiry _____/_____ SVC/CVV: _____

Name on Card: _____

Signature of Card Holder: _____

We do our best to respect our patient's time and turn we ask the same courtesy. Therefore, our office requires a minimum of 2 business days notice to cancel or change a schedule appointment. If we are not provided with such notice or an appointment is missed, a $50 fee will be charged. This fee must be paid prior to any further appointments. We appreciate your understanding and cooperation with this.

Signature:_____
Date: _____

Discover Dental – Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information, when required by law.

We collect information from our patients such as name, home address, work address, contact telephone numbers, e-mail address, birthdays and other government, corporate and/or personal data (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 cards payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third party health benefit provided and insurance companies.
- To send reminders and/or phone patients concerning the need for further dental examination or treatment.
- To send patients information material about our dental practices

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 patients' 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:
- 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 patients' behalf.
- To other Dentists and Dental Specialists where we are seeking a second opinion and the patient has consented to us obtaining a 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 is, 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, as part of the due diligence process, qualified potential purchasers may be granted access 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.

** Also effective July 1, 2014 Canada's Anti Spam Legislation along with existing privacy laws require us to obtain your consent so you can receive / continue to receive email communication from us.

I consent to the collection, use and disclosure of my personal information & / or the minor children under my guardianship that attend this practice,_____ (initials)

I consent to receive emails from this office. My Email address will never be given out to anyone other than specialists I approve being referred to._____ (initials)

Printed Patient Name: _____

Email: _____

Dated: _____

Signature of Patient or Guardian: _____