DIAMOND DENTAL PERSONAL INFORMATION CONSENT FORM

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstance described in the form, we also collect, and disclose personal information when permitted or required by law.
We collect information from our patients such as name, home address, work address, home telephone number, cell phone number, work telephone number, and e-mail address. (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 informative 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 physical condition, and dental treatment. (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 benefits providers and insurance companies where the patient has to submit a claim for reimbursement or payment of all of the cost of dental treatment or has asked us to submit a claim on patients' 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 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 professional 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 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.

I authorize release, to my insuring company plans administrator, the information contained in claims submitted electronically and/or manually.

I consent to collection, use and disclosure of my personal information as set out above.

Date	Print Name	Signature

WELCOME
TO DIAMOND DENTAL

We are looking forward to having you join our great family of friends and patients.
The benefits of a healthy, beautiful smile are immeasurable and our goal is to obtain the healthy teeth and attractive smile you want and deserve.

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. PLEASE PRINT.

Date:_____

REGISTRATION INFORMATION

The patient is an: Adult ☐ Adult under guardianship ☐ Child ☐ Name of Guardian: _____

Name: _____ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐
(last) (first) (initial)

Address: _____
(street) (apt.#) (city) (province) (postal code)

Reason for today's visit? Examination ☐ Other ☐ _____

A.H.C.#: _____ Preferred appt. time? _____

Home Phone: ( )_____ Bus Phone: ( )_____ Ext._____ May we call you at work? ☐

Email Address:_____

PERSONAL INFORMATION

Prefers to be called:_____ Occupation:_____

Date of Birth: M ____ D ____ Y ____ Age: ____ Sex: ____ Marital Status: _____ Name of Spouse: _____

Are other family members patients at our office? Yes ☐ Names: _____

How did you hear about our office? ☐ Friend/Relative ☐ Yellow Pages ☐ Advertising ☐ Other _____

Whom may we thank for referring you?_____

MEDICAL PRIORITY

Family Physician_____ Phone: ( ) _____

Medical Specialist: _____ Phone: ( ) _____
(if presently under care)

In case of emergency, please contact:_____ Phone: ( ) _____

FINANCIAL INFORMATION

Person responsible for account: Self ☐ Spouse ☐ Other ☐ _____ **Please complete all information if different than above.**

Name:_____ Phone: ( ) _____
(last) (first) (initial)

Address: _____
(street) (apt. #) (city) (province) (postal code)

Employed by: _____ Phone: ( ) _____

PATIENT REGISTRATION DENTAL HISTORY

DENTAL HISTORY

Please ✓ YES or NO to each question. If unsure of a question, please consult with the dentist or receptionist.

Is there a dental problem you would like treated immediately? Yes ☐ Problem: _____ ☐ No

Are there any other dental conditions that concern you at present? Yes ☐ Condition: _____ ☐ No

Date of your last dental visit?_____ Last dental cleaning? _____ Last x-rays? _____

	YES	NO
1. Have you been seeing a dentist regularly?	☐	☐
2. Have you ever had any of the following?		
-Periodontal Treatment? (treatment of the gums)	☐	☐
-Orthodontic Treatment? (to straighten or realign teeth)	☐	☐
-A bite plate, night guard or any other appliance?	☐	☐
-Crowns or Bridges?	☐	☐
-Dentures or Partial Dentures? (circle)	☐	☐
-Wisdom Teeth Removal?	☐	☐
-Root Canal Treatment?	☐	☐
3. Are there any growths or sore spots in your mouth?	☐	☐
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums?	☐	☐
5. Have you noticed any loose teeth, or, have any of your teeth shifted?	☐	☐
6. Does food catch between your teeth?	☐	☐
7. Are any of your teeth sensitive to heat, cold, sweets or pressure? (circle)	☐	☐
8. Have you ever experienced any of the following jaw problems:		
-Popping/clicking in your jaw joints?	☐	☐
-Pain in your jaw joints, around your ear, or side of your face?	☐	☐
-Difficulty in opening or closing?	☐	☐
-Pain when teeth are clenched?	☐	☐
-Pain or difficulty while chewing?	☐	☐
9. Do you have any of the following habits?		
-Clenching or grinding your teeth while awake or asleep?	☐	☐
-Biting your cheeks or lips?	☐	☐
-Mouth breathing while awake or asleep?	☐	☐
-Gag reflex: slight____ moderate____ severe	☐	☐

10. Are you missing any teeth? ☐ Yes ☐ No If so, have they been replaced? ☐ Yes ☐ No If not, would you like them replaced? ☐ Yes ☐ No

11. Are you unhappy with the appearance of your teeth?	☐	☐
and, What would you like to see changed?	☐	☐
12. Do you have any concerns about halitosis (bad breath)?	☐	☐
13. Are you interested in any of the following? (Please ✓)	☐	☐

☐ Teeth whitening or bleaching
☐ Treatment of bad breath (halitosis)
☐ Orthodontic treatment
☐ Cosmetic dentistry
☐ Digital imaging (computer modification of a digital photograph of your teeth to show you what changes would look like)

14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns?	☐	☐

OFFICE POLICY

APPOINTMENTS

Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore at least 24 HOURS NOTICE **MUST** be given if cancellation is absolutely necessary.

PAYMENT OF FEES

1. This office is willing to accept direct payment from your dental plan for services which your plan covers.
2. If your dental plan does not cover the full cost of your treatment, you will be responsible for any difference between the amount paid by your plan and the amount charged.
3. Your portion is then due and payable on the day of your appointment unless other financial arrangements have been made. There will be a 1.5% administration fee per month on all accounts over 30 days old.
4. You are responsible for providing the necessary information in order for us to direct bill your insurance company as well as informing us of any changes in this information.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information.

CONSENT

I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and consent to the use of local anaesthetic agents. I understand the above statements regarding the payment of fees and accept the responsibility for payment for Dental Services provided for myself or my dependents, due and payable when services are rendered unless other financial arrangements have been made.

Patient Signature:_____ Date: _____ Witness: _____

Parent or Responsible Party:_____ Relationship to Patient: _____

Last Name:	First	Middle

Please ✔ YES or NO to each question. If unsure of a question, please consult with the dentist or receptionist.

	YES	NO
1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: _____	☐	☐
2. Have you been hospitalized in the past two years? _____	☐	☐
3. When was your last visit to a Physician? _____ Last complete physical examination? _____		
4. Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Please list: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	☐	☐
5. Have you ever reacted adversely to any of the following? (Please circle.) ANTIBIOTICS - Penicillin, Erythromycin, Dalacin, Sulfa, or other antibiotics, ASPIRIN, VALIUM, CODEINE, NARCOTICS, LOCAL ANAESTHETIC (freezing), any other medicine: _____	☐	☐
6. Have you ever been advised against taking any specific type of medication? _____	☐	☐
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? _____	☐	☐
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: _____	☐	☐
9. Have you been advised by your Medical Doctor or Dentist to take antibiotics prior to dental treatment? _____	☐	☐
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? _____	☐	☐
11. Do you **Snore Loudly** (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)? _____	☐	☐
12. Do you often feel **Tired, Fatigued, or Sleepy** during the daytime (such as falling asleep during driving or talking to someone)? _____	☐	☐
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? _____	☐	☐
14. Have you tested HIV positive, or come in contact with the AIDS virus? _____	☐	☐
15. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? _____	☐	☐
16. Have you ever had any injury or surgery to your face or jaws? _____	☐	☐
17. Do you smoke or use any other forms of tobacco? _____	☐	☐
18. Are you alcohol and/or drug dependent? _____ and, Have you received treatment? _____	☐	☐

19. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

	YES	NO		YES	NO			
Anemia	☐	☐	Heart disease or attack	☐	☐	Malignant Hyperthermia	☐	☐
Angina pectoris	☐	☐	Heart murmur	☐	☐	Metal allergy	☐	☐
Arthritis/rheumatism	☐	☐	Heart pacemaker	☐	☐	Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐	Heart rhythm disorder	☐	☐	Organ transplant/medical implant	☐	☐
Artificial joints (hip, knee)	☐	☐	Heart surgery	☐	☐	Psychiatric treatment	☐	☐
Blood disorders	☐	☐	Hepatitis A	☐	☐	Radiation treatment/chemotherapy	☐	☐
Bronchitis	☐	☐	Hepatitis B	☐	☐	Rheumatic/Scarlet fever	☐	☐
Cancer	☐	☐	Hepatitis C	☐	☐	Sickle cell disease	☐	☐
Circulation problems	☐	☐	HIV	☐	☐	Sinus trouble	☐	☐
Congenital heart lesions	☐	☐	High blood pressure	☐	☐	Stomach/intestinal problems	☐	☐
Cortisone/steriods	☐	☐	Low blood pressure	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Hodgkins disease	☐	☐	Thyroid disease	☐	☐
Emphysema	☐	☐	Hyper (Hypo) Glycemia	☐	☐	Tuberculosis	☐	☐
Epilepsy or seizures	☐	☐	Jaundice	☐	☐	Ulcers	☐	☐
Fainting or dizzy spells	☐	☐	Kidney disease	☐	☐	Other _____	☐	☐
Glandular disorders	☐	☐	Latex allergy	☐	☐	Other _____	☐	☐
Glaucoma	☐	☐	Liver disease	☐	☐	Other _____	☐	☐
Head/neck injuries	☐	☐	Lung disease	☐	☐	Other _____	☐	☐

20. WOMEN ONLY: Are you pregnant or suspect you may be? _____	☐	☐
If yes, what is the expected delivery date? _____ Are you taking any birth control pills? _____	☐	☐
21. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? _____	☐	☐
22. Is there anything else about your health we should be made aware of? _____	☐	☐
23. Do you wish to speak to the Doctor privately about any problem or medical condition? _____	☐	☐

MEDICAL HISTORY MEDICAL HISTORY UPDATES

DIAMOND DENTAL CONSULTING

Dr. Jerrold Diamond & Associates
17238 – 95 Avenue
Edmonton AB T5T 6P1
Canada

Ph: (780)489-6700

Fax: (780)444-3868

diamonddental@shaw.ca

I _____ authorize the release and request the transfer of the following records to Diamond Dental Consulting on my behalf.

_____ _____

Signature **Date (MM/DD/YYYY)**

Previous Dentist office: _____

Address: _____

Phone: _____ **Fax:** _____

(BELOW FOR OFFICE USE)

Dear Dr. _____

Re: _____

_____

_____

_____

_____

Would you kindly forward the following patient records:

PLEASE send the radiographs in separate emails if they were taken at different dental visits with the exact dates in the email body! Thanks!

- **Date of last New Patient exam (MM/DD/YYYY):** _____
- **Date of last Recall Exam/Polish (MM/DD/YYYY):** _____
- **Any digital BW's going back up to 10 years- with exact – Date(s):** _____
- **Any digital PA's going back up to 10 years - with exact - Date(s):** _____
- **Any digital PAN's going back up to 10 years - with exact - Date(s):** _____
- **Report Letters/Dates from most recent referring specialist(s):** _____
- **Clear Scanned to Email copy of last two periodontal probe readings/dental charting - with exact - Date(s):** _____

Thank you very much!

Dr. Jerrold Diamond

Dr. Costantino Renzi

Dr. Curtis Winand

Dr. Lori Russett

DIAMOND DENTAL
17238-95 Ave. NW
Edmonton, AB T5T 6P1
diamonddental@shaw.ca

Email Consent Form

As you are probably already aware the new Anti-Spam Legislation went into effect in Canada July 1, 2014. This new law regulates how businesses like ours can communicate with you using electronic messages.

These electronic messages could include:

- Email reminders for appointments
- Emails following appointments
- Contest invitation emails
- Special Events, promotions for Diamond Dental
- Electronic Statements, Invoices, Receipts, Insurance Claim forms

We appreciate the opportunity to keep in touch with you via electronic correspondence. If you would like to consent to keeping in touch through electronic messages from Diamond Dental please check mark to accept and enter your email address.

□ Yes, I agree to accept/subscribe to electronic correspondence from Diamond Dental for: _____
Patient name(s)

Email Address: _____

Signature: _____

Date: _____

□ No, I do not agree to receive electronic correspondence from Diamond Dental for:

_____
Patient name(s)

Signature: _____

Date: _____

You may withdraw consent or modify your consent at any time. If consent is withdrawn it will be processed within 10 business days from the request.

Email Address to withdraw: _____

Patient(s) Name: _____

Signature: _____

Date: _____

Insurance Express Check Out Form

Patient Name: _____ Date: _____

With the introduction of the new Health Information Act and the diversity of dental benefit packages, more and more dentists are not accepting insurance as payment. It is difficult to maintain accounts with a zero balance because of difficulty in estimating what your insurance payments will be. It has been time consuming and difficult for us to continually collect or refund balances remaining, after insurance payments are received. We would rather invest our time ensuring that optimal dental care is given. We would like to be able to offer our new and existing patients flexibility in paying for dental treatment with the following options:

OPTION 1: Fee For Service

This option allows you to be in control of your insurance benefits, by paying in full at each appointment for treatment and being reimbursed directly by your insurance company. This will allow you to keep personal records of all dental transactions, all insurance reimbursements, track maximum allowable benefits and you will be more aware of what your plan does and does not cover. When insurance companies are reimbursing patients, payment usually takes 1-2 weeks to be received, especially if your plan accepts electronic dental claims. If required, we will send electronic claims for you at each appointment.

OPTION 2: VIP Express Checkout

Our VIP Express Checkout Program allows us to continue to offer you the convenience of using your insurance plan as a form of direct payment. Please complete the information below. It will be kept confidential and used only under the agreed terms. **It should be noted that due to the constraints of the Privacy Act, we are unable to obtain information about your coverage from your insurance company. As such, it is your responsibility to know the details of your coverage, and to communicate these details to us.** We will provide you with a brochure outlining the specific information you must gather from your insurance company. **If you are unable to provide details about your plan, we will use Option 1: Fee for Service for your treatment.**

Patient Agreement

I agree to the financial responsibility for the following: **The out of pocket portion and balance not covered by insurance.**

I, _____, authorize Dr. _____ to keep my credit card number on file and to issue a credit or debit memo to my credit card account for any over and under payment once my insurance portion has been received. I will be notified by phone or mail if any charge or credit is in excess of $200.00. I give permission for any claim not paid by my insurance company to be automatically put through on my credit card. A receipt for this transaction will be mailed with a statement of account.

Signature: _____ Date: _____

Payment by: ☐ Visa ☐ Mastercard

Credit card number: _____

Expiry date: _____

Name on the card: _____

Signature: _____

I do not have a credit card, but I have permission for you to use a family member or spouse's card.

Name: _____

Relationship to this person: _____

Their phone number: _____

Credit card information provided above.