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

Tell Us About Your Child

Today's Date _____ Child's Home Phone #: (____) _____ S.I.N. # _____

Child's Name: _____ Child's Birthdate: D / M / Y Child's Age _____
(Last) (First) (Int.)

Nickname: _____ ❑ Male ❑ Female School _____ Grade _____

Child's Home Address: _____
Street City Prov. Postal Code

Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No Is this child adopted? ❑ Yes ❑ No Is the child in a foster home? ❑ Yes ❑ No

Whom may we Thank for referring you? _____ Other siblings seen by us: _____

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #:(____)_____ Home Phone#:(____)_____

Address: _____
Street City Prov. Postal Code

Parent's Information

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Remarried ❑ Single

❑ Mother: ❑ Step Mother ❑ Guardian Birthdate: ___/___/___ Home Phone #: (____)_____ Work Phone #:(____)_____

Name: _____ S.I.N.# _____ Driver's License #: _____

Address: _____
Street City Prov. Postal Code

Employer: _____ Length of Employment: _____

❑ Father: ❑ Step Father ❑ Guardian Birthdate: ____/____/____ Home Phone #:(____)_____ Work Phone #:(____)_____

Name: _____ S.I.N.# _____ Driver's License #: _____

Address: _____
Street City Prov. Postal Code

Employer: _____ Length of Employment: _____

Person Responsible for Account

Name: _____ Relation: _____ S.I.N.# _____

Billing Address: _____
Street City Prov. Postal Code

Work Phone #: _____ Home Phone # _____ Employer: _____ Driver's License: _____

Who is responsible for making appointments?

Name: _____ Work Phone #:(____)_____ Home Phone #:(____)_____ Best time to call: _____

Insurance Information

Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
Street City Prov. Postal Code

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ S.I.N.# _____ Policy Owner's Employer: _____

Employer's Address: _____
Street City Prov. Postal Code

Medical Coverage? ❑ Yes ❑ No Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
Street City Prov. Postal Code

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ S.I.N.# _____ Policy Owner's Employer: _____

Employer's Address: _____
Street City Prov. Postal Code

PATIENT REGISTRATION **DENTAL HISTORY**

Dental History

Is the child currently in pain? ❑ Yes ❑ No What is the primary reason for today's visit? _____

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Has the child experienced problems with previous dental work? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No Is the child taking fluoridated supplements? ❑ Yes ❑ No

Does the child brush his / her teeth daily? ❑ Yes ❑ No Floss his / her teeth daily? ❑ Yes ❑ No

Previous / Present Dentist: _____ Date of last visit: _____
(Please circle)

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least about? _____

Does / did the child have any of the following habits?

Y	N	Breast Fed	Y	N	Mouth Breather	Y	N	Thumb / Finger sucker
Y	N	Chewing on Objects	Y	N	Nail Biting	Y	N	Tongue / Cheek Biting
Y	N	Clenching / Grinding Teeth	Y	N	Nursing Bottle Habits	Y	N	Tongue Thrust
Y	N	Lip Sucking / Biting	Y	N	Speech Problems	Y	N	Used Pacifier

Medical History

Child's Physician: _____ Phone #: (_____) _____ Date of last visit: _____

Address: _____
Street City Prov. Postal Code

Is the child currently under the care of a physician ❑ Yes ❑ No Please explain: _____

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor Are Immunizations current? ❑ Yes ❑ No

Please list all drugs that the child's currently taking: _____

Please list all drugs and/or other things that cause the child allergic reactions: _____

Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No

Has the child had/experienced any of the following:

Y	N	Abnormal Bleeding	Y	N	Diabetes	Y	N	Low Blood Pressure
Y	N	AIDS/HIV+	Y	N	Epilepsy	Y	N	Lupus
Y	N	Allergies	Y	N	Handicaps / Disabilities	Y	N	Measles
Y	N	Anemia	Y	N	Hearing Impairment	Y	N	Mitral Valve Prolapse
Y	N	Any Hospital Stays / Operations	Y	N	Heart Murmur	Y	N	Mononucleosis
Y	N	Asthma	Y	N	Hemophilia	Y	N	Rheumatic Fever
Y	N	Blood Transfusion	Y	N	Hepatitis	Y	N	Scarlet Fever
Y	N	Cancer	Y	N	High Blood Pressure	Y	N	Sickle Cell Anemia
Y	N	Chicken Pox	Y	N	Hives	Y	N	Skin Rash
Y	N	Congenital Heart Defect	Y	N	Kidney Problems	Y	N	Tonsillitis
Y	N	Convulsions	Y	N	Liver Problems	Y	N	Tuberculosis (TB)

Please discuss any serious medical problems the child experiences/ed: _____

_____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. My method of payment will be _____

_____
Signature of parent or guardian Date

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance subdivisions, whether manual or electronic.

_____
Signature of parent or guardian Date

The parent or guardian who accompanies the child is responsible for payment at time of service.

PPB Enterprises Inc. 1-877-480-2284 Form #996

DIAMOND DENTAL CONSULTING

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Email: natalie@diamonddental.org
Email: vanessa@diamonddental.org
Email: debby@diamonddental.org
Email: tammy@diamonddental.org

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

_____ _____

Signature **Date**

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:** _____
- **Date of last Recall Exam/Polish:** _____
- **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

Insurance Express Check Out Form

Patient Name: _____ Date: _____

With the introduction of the new Health Privacy 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.

DIAMOND DENTAL
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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: _____