AJL DENTISTRY

NEW PATIENT FORM

We are committed to providing you with the most comprehensive care and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better care we can give you. If you have any questions or need assistance, please ask us and we will be happy to help!

ABOUT YOU

Name:_____ Preferred name: _____

Date of Birth:_____ Age: _____ Marital Status: _____

Address: _____ Postal Code: _____

Home phone: _____ Work: _____ Ext.: _____ Cell: _____

Email Address: _____

Preferred method of contact: Text Call Email

PERSON RESPONSIBLE FOR ACCOUNT

(Please skip if same as above)

Name: _____ DOB: _____ Relation: _____

Billing Address: _____ Postal Code: _____

Home phone: _____ Work: _____ Ext.: _____ Cell:_____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Company: _____ Phone: _____

Policy #: _____ ID #: _____

Insured's Name: _____ Insured's DOB:_____ Relation: _____

Employee # (if applicable): _____ Insured Employer: _____

Secondary Insurance: Yes No

Insurance Company: _____ Phone: _____

Policy #: _____ ID #: _____

Insured's Name: _____ Insured's DOB:_____ Relation: _____

Employee # (if applicable): _____ Insured Employer: _____

Who may we thank for referring you?

Internet Outside Sign Mail/Advertisement I live in the area

Other: _____

Referred by: _____

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MEDICAL HISTORY

Family Physician: _____ Phone Number: _____

1. Do you visit your family physician regularly?..... Yes No
2. Have you ever been hospitalized? ..... Yes No
   If yes, why? _____ What year? _____
3. Have you experienced any unusual reactions or allergies to any of the following? *(If yes, please circle)*
   Aspirin Penicillin Valium Codeine Local Anaesthetic Latex/Rubber Products Food
   Other _____
   What is the severity of the reaction? _____
4. Have you had any reactions to local anesthetic? ..... Yes No
5. Do you have anemia or bleed abnormally? ..... Yes No
6. Have you ever had any of the following diseases or conditions? (If yes, please circle yes or no)

Cardiovascular

Angina	*Yes No*	*Stroke*	*Yes No*
Chest pain	*Yes No*	*Heart disease/attack*	*Yes No*
Endocarditis	*Yes No*	*Prosthetic Heart Valve*	*Yes No*
Heart Transplant	*Yes No*	*Congenital heart lesions/defects*	*Yes No*
Heart pacemaker	*Yes No*	*Heart Murmur*	*Yes No*
Heart rhythm disorder	*Yes No*	*Heart surgery*	*Yes No*
Hypertension	*Yes No*	*Ankle feet, hands swell*	*Yes No*
Circulation problems	*Yes No*	*Heart or blood pressure problems*	*Yes No*
Mitral valve prolapse	*Yes No*	*Rheumatic fever*	*Yes No*

Respiratory

Asthma	*Yes No*	*Bronchitis*	*Yes No*
Shortness of breath	*Yes No*	*Emphysema*	*Yes No*
Lung disease	*Yes No*	*Tuberculosis*	*Yes No*

Endocrine

Diabetes	*Yes No*	*Hypoglycemia*	*Yes No*
Glandular disorders	*Yes No*	*Thyroid disease*	*Yes No*

Skeletal

Arthritis	*Yes No*	*Past injury/surgery to jaw/face*	*Yes No*
Head/Neck injury	*Yes No*	*Artificial joints (hip/knee)*	*Yes No*

Blood/Immune

HIV/AIDS	*Yes No*	*Anemia*	*Yes No*
Blood disorders	*Yes No*	*Sickle cell disease*	*Yes No*
Bleeding disorder	*Yes No*		

GI

Crohn's disease	*Yes No*	*Inflammatory bowel disease*	*Yes No*
Ulcers	*Yes No*		

Other

Liver disease	*Yes No*	*Jaundice*	*Yes No*
Hepatitis A, B, C	*Yes No*	*Kidney disease*	*Yes No*
Cancer	*Yes No*	*Chemo/Radiation*	*Yes No*
Hodgkin's disease	*Yes No*	*Glaucoma*	*Yes No*
Herpes/Cold sores	*Yes No*	*Malignant Hyperthermia*	*Yes No*
Lupus	*Yes No*	*Medical implant*	*Yes No*
Organ transplant	*Yes No*	*Hearing difficulty*	*Yes No*
Sinus Problems	*Yes No*	*Cortisone/Steroid*	*Yes No*
Seizures/Epilepsy	*Yes No*	*Fainting/Dizzy spells*	*Yes No*
Mental/nervous disorder	*Yes No*	*Venereal disease*	*Yes No*

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Continued .... **MEDICAL HISTORY**

7. Please list any <u>medications</u> you are taking: _____
_____
_____

8. Do you require antibiotic premedication for dental work? …….. Yes No
9. Are there any other medical problems we should be aware of? ..... Yes No
If yes, please explain: _____

10. **Women**:
Are you presently pregnant? ..... Yes No
If yes, how many months? _____
Are you breast feeding? ..... Yes No
If yes, how many months? _____
Are you taking Birth Control pills?..... Yes No

SOCIAL HISTORY

How many alcoholic beverages do you consume in a week? _____
Do you smoke, vape or use tobacco?..... Yes No
Do you use any recreational drugs? ..... Yes No

Notes: _____
_____
_____
_____
_____

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I authorize the dentist to preform procedures and consent to the treatment including the use of local anaesthetic, oral sedation, and I will assume responsibility for fees associated with those procedures. I authorize the release of my personal information regarding my diagnosis or treatment to my insurance company or any other dental profession.

_____ _____
Signature: Patient/Parent Guardian Date

_____
Print name of Parent /Guardian

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DENTAL HISTORY

Reason for today's visit? Check-up Cleaning Toothache Other: _____

1. Who was your previous dentist? _____
2. When was your last dental visit? _____
3. What was done at that time? _____
4. Have you experienced difficulties with past dental treatments? ..... Yes No
5. On a scale of 1-10 *(1 not nervous/anxious and 10 extremely nervous or anxious)*
   How do you feel about visiting the dentist? _____
6. Do you have any pain/sensitivity?..... Yes No
7. Do you suffer from HEADACHES? ..... Yes No
8. Do you grind your teeth? ..... Yes No
9. Do you have TMJ problems?..... Yes No
10. Do you have bleeding gums?..... Yes No
11. Do you have bad breath?..... Yes No
12. Would you be interested in tooth bleaching? ..... Yes No
13. Are you happy with your smile? ..... Yes No

Please rate your smile: *Lowest 1 2 3 4 5 6 7 8 9 10 Highest*

Notes: _____
_____
_____
_____
_____

Signature: _____ Date: _____

Name: _____
(please print)

AJL DENTISTRY

Dental Office 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 and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described 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 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 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 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.

I consent to the collection, use and disclosure of my personal information as set out above.
I authorize release, to my insuring company, plan administrator and the CDA the information contained in claims submitted electronically.

_____	_____	_____
Print Name	***Signature***	***Date***

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APPOINTMENT POLICY

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. Our office policy states that patients must give us 1 business day (24 hours) notice if they cannot keep an appointment. Appointment changes with less than **24 hours notice** are subject to a **$60.00** service fee. It is my responsibility to **confirm appointments** and I understand that if I do not confirm my appointment, there is a risk of the appointment being rescheduled. Patients that do not show up for their appointments may not be booked again.

INITIALS _____

FINANCIAL POLICY

For your convenience, our office can directly bill your insurance company, the estimated patient portion will be the balance due at the end of treatment. We do accept Cash, Debit, Visa and MasterCard. Dental Insurance plans often pay less than the actual fee for service. Therefore, you are responsible for all costs that the dental insurance plan does not cover. If you would like to know what your insurance plan(s) will cover, please ask us and we can ask your insurance company. We encourage patients to have per-authorizations for all major work (Crowns, Bridges, Veneers) to have a better idea of what your insurance plan will cover.

INITIALS _____

AUTHORIZATION AND CONSENT FOR INSURANCE ASSIGNMENT

General consent for CDA net
I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to **Dr Anthony Leung** with **AJL Dentistry**.

INITIALS _____

General consent for assignment of benefits VIA CDA net
I hereby assign my benefits, payable form claims submitted electronically, to **Dr. Anthony Leung** with **AJL Dentistry** and authorize payment directly to him.

INITIALS _____

Assignment of Insurance Benefits
I authorize and request my insurance company to pay my benefits directly to **Dr. Anthony Leung** with **AJL Dentistry**. This authorization shall continue in effect until the undersigned revokes the same.

INITIALS _____

_____	_____	_____
Print Name	***Signature***	***Date***