INSURANCE INFORMATION

Insurance Company: _____

Group/Policy #_____ ID#_____

Policy Holder Full Name and Birthdate (dd/mm/yy)

_____

Thank you for visiting Cedar Ridge Dental. We want your visit to be pleasant and comfortable. Please assist us by completing this form.

Patient Information

❑ Male ❑ Female

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Home Address _____
STREET/BOX NUMBER/RR

_____
CITY PROVINCE POSTAL CODE

Family Doctor _____

Birth date (dd/mm/yy) _____ Phone (___) _____ Clinic _____

Phone: Home (___) _____ Previous Dentist _____

Work (___) _____ Phone (___) _____ Clinic _____

Mobile (___) _____ Date of last dental visit _____

Email _____ Did you have xrays taken? ❑ YES ❑ NO

Alberta Health Care #_____ **Treaty #** _____

Employer _____

Emergency Contact: Name _____ Phone (___) _____

Relationship _____

Other Information

Who can we thank for referring you to us/how did you hear about us? _____

What is the reason for today's visit? _____

Why did you leave your previous dentist?_____

What did you like *most* about your previous dentist?_____

Insurance Authorization Statement (PLEASE Sign & Date)

Payment for all treatment and services rendered are my responsibility.

As a courtesy to you we direct bill most insurance companies. However, in the event that we are not able to claim monies for service rendered after 90 days we will forward the bill to you and you will have to deal with your insurance company directly. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Signature_____ **Date** _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____
STREET CITY PROVINCE POSTAL CODE

Phone (___) _____

Medical History and Information

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private, and is protected by doctor-patient confidentiality.
lease fill in the entire form.

1. Are you being treated for any medical condition at present or have you been treated within the past year? If so, why?
   ❑ YES ❑ NO

2. When was your last medical check-up?

3. Has there been any change in your general health in the past year? If yes, please explain.
   ❑ YES ❑ NO

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list?
   ❑ YES ❑ NO

5. Have you ever had a peculiar or adverse reaction to any medications or injection? If yes, please explain.
   ❑ YES ❑ NO

6. Do you have or have you ever had any heart or blood pressure problems? If yes, please explain.
   ❑ YES ❑ NO

7. Have you ever been advised by your doctor to take antibiotics before dental treatment?
   ❑ YES ❑ NO

8. Do you have a bleeding problem or bleeding disorder?
   ❑ YES ❑ NO

9. Have you been hospitalized for any illness or operation in the past five years? If yes, please explain.
   ❑ YES ❑ NO

10. Are there any disease or medical problems that run in your family? If so, please list.
    (eg. diabetes, cancer, or heart disease.)
    ❑ YES ❑ NO

11. Are you nervous during dental treatment? ❑ YES ❑ NO

Do you have or have you ever had any of the following? Please check all that apply.

Conditions

- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease/Hemophilia
- ❑ Cancer/Chemotherapy
- ❑ Diabetes
- ❑ Dizziness/Fainting
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Excessive Bruising
- ❑ Frequent Headaches
- ❑ Gastro-Intestinal
- ❑ Glaucoma
- ❑ Hard to Freeze
- ❑ Hay Fever
- ❑ Head Injury
- ❑ Hearing Impaired
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ HIV+ Aids
- ❑ High Blood Pressure
- ❑ Hives
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Multiple Sclerosis
- ❑ Nervous Disorders
- ❑ No Epinephrine
- ❑ Pace Maker
- ❑ Psychiatric Problems
- ❑ Radiation Therapy
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Rheumatoid Arthritis
- ❑ Seizures
- ❑ Sinus Problems
- ❑ Skin Rash
- ❑ STD
- ❑ Shingles
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ TMJ
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Wheelchair

Allergies

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Metals
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other _____

Y	N	
❑	❑	Do you Smoke or use Tobacco?

If Female

Y	N	
❑	❑	Are you taking Birth Control Pills?
❑	❑	Are you pregnant? If yes, # of weeks _____
❑	❑	Are you nursing?

	Yes	No	
Are there any conditions or disease not listed above that you have or have had?	❑	❑	If so, please list:

_____

Treatment Authorization Form

I authorize and give consent to Cedar Ridge Dental to perform dental services agreed between the doctor and patient and/or parent or guardian deemed to be necessary or advisable, including the use of local anesthesia and other medication as indicated. I certify the above statements regarding medical condition are correct. The information on this page and the medical history is correct to the best of my knowledge.

_____ _____

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Payment Options

You must choose a single option.

Thank you for choosing Cedar Ridge Dental. We are pleased to offer you a few different payment options.

_____**Option 1:** Payment is due in full the day treatment is rendered. We accept, cash, Cheques, debit, Visa, Master Card and American Express.

_____**Option 2:** You have **one** insurance. As a courtesy to you we direct bill over the internet for instant authorization. Payment of what is not covered under your insurance plan will be made the same day. If your insurance does not give us instant feedback you will pay an estimated amount on what is usually covered under your plan. If there is a balance remaining due to this estimation you will be required to come back in to pay the balance, or you may leave a credit card on file.

_____**Option 3:** If you have **two** insurances you will need to leave your credit card number on file and we will directly bill your insurance companies. Once your insurance companies have paid us their portion, (4-6 weeks) our office team will process your patient portion to the credit card on file.
If your balance is under $75 it will be processed immediately anything over $75 you will receive a courtesy call telling you when your card will be processed.

I, _____, have chosen **Option 2/3**, and I hereby authorize any balances not covered by my insurance for me and/or my family members to automatically be applied to the following credit card:

Card type:

- ☐ Visa
- ☐ Master card
- ☐ American express

Name (as it appears on card) _____

Card number _____

Expiry date _____ 3 digit _____

Card Holder Signature_____