Banff Dental Care

Dr. Christie Foreman & Associates
307- 220 Bear St., PO Box 1138
Banff, Alberta T1L 1B1
P: 403-762-3979 F: 403-762-4959

REGISTRATION

First Name_____ Last Name _____ Date of Birth (d) _ _ /(m) _ _ /(y) _ _ _ _
Address _____PO Box # (if in Banff)_____City/Town _____ Postal Code _____
Home Phone #_____Cell #_____ E-mail _____
Gender (circle) M / F Driver's License _____ SIN /SSN _____
Emergency Contact (name + number) _____ Relationship _____

How did you hear about us?

Our webpage (Google) ☐ Employer ☐ Walked-by ☐
Social Media (Facebook/Twitter) ☐ Newspaper Ad ☐ Yellow Pages (Online) ☐
Word of Mouth ☐ Community Presentation ☐ Other: ☐ _____

If you were referred by word of mouth, whom may we thank for the referral? _____

PRIMARY INSURANCE INFORMATION (if applicable):

Employer: _____ Work Phone # _____
Account Holder's Name: _____Holder's D.O.B. d/m/y _____
Relation to Holder (please circle) Self / Spouse / Child / Other _____
Insurance Carrier _____Policy/Group# _____ ID or Certificate # _____

SECONDARY INSURANCE INFORMATION (if applicable):

Employer: _____ Work Phone # _____
Account Holder's Name: _____Holder's D.O.B. d/m/y _____
Relation to Holder (please circle) Spouse / Child / Common-law / Other _____
Insurance Carrier _____ Policy/Group # _____ ID or Certificate # _____

DENTAL HISTORY

Who was your previous dentist? _____Where was that office located? _____
Approximately when was your last dental examination? _____ Last cleaning? _____
Have you had X-rays in the last year? Yes [ ] No [ ] If yes, would you like us to request them? _____
Do your gums bleed when you brush? Yes [ ] No [ ]
Are any of your teeth sensitive to: Cold/Heat [ ] Sweets [ ] Chewing [ ] Not Sensitive [ ] Other? _____
Have you ever had abnormal bleeding associated with a previous extraction? Yes [ ] No [ ] Not Sure [ ]
Do you have dental anxiety? Yes [ ] No [ ] (Comment if you wish) _____
What can we do to surpass your expectations?

_____

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DENTAL HISTORY CONT'D

Reason for your visit (check all that apply):

___Regular checkup/cleaning ___I'm grinding or clenching my teeth ___My teeth are misaligned
___My gums are sore or bleed ___I have a toothache ___I want cosmetics/whitening
___My jaw is sore or swollen ___I think I have a cavity ___Need mouthguard/appliance

Other (please explain): _____

MEDICAL HISTORY

Your Physician's Name _____ Year Of Last Complete Exam_____ Telephone #_____

Are you under the care of a doctor/specialist for ongoing health issues?	yes	no	If yes, for what?
Have you ever had any serious illness or hospitalization?	yes	no	If yes, describe:
Have you had a serious injury to your head, neck or face?	yes	no	If yes, for what?
Do you have any artificial joints or artificial heart valve?	yes	no	If yes, describe:
Have you had heart problems or a cardiac stent?	yes	no	If yes, when?
Have you had a heart murmur, endocarditis, or rheumatic fever?	yes	no	
Have you taken antibiotics one hour before dental visits (for heart/joint)?	yes	no	
Do you have a pacemaker or implantable defibrillator?	yes	no	
Have you ever had radiation or chemotherapy?	yes	no	
Are you taking blood thinners?	yes	no	
Have you ever had prolonged bleeding that won't stop?	yes	no	
Do you have a history of sleep apnea?	yes	no	
MALE - Are you taking erectile dysfunction medications?	yes	no	
FEMALE - are you pregnant?	yes	no	

Please list all medications you are currently taking, including contraceptives, supplements, and/or herbal medications:

Have you ever had an allergic reaction to: *Please circle*

Latex	Codeine/aspirin/ibuprofen	Local anesthetic	Metals	Diet allergy/intolerance
Penicillin	Other _____	Fluoride	Sulfa	Environmental allergy

Have you ever had any of the following? *Please Circle*

High/Low Blood Pressure	Kidney disease	Stomach /Digestive or ulcers	HIV/AIDS
Angina/Heart Attack	Liver disease	Arthritis/Rheumatoid Arthritis	Fainting Spells
Stroke	Congenital heart disease	Epilepsy/convulsions/seizure	Psychiatric/depression
Emphysema	Thyroid	Pulmonary (lungs)	Alcohol/ Drug dependency
Asthma	Hormonal deficiency	Viral infections/cold sores	Cancer
Tuberculosis	Diabetes (Type I or II)	Hepatitis A, B or C	Blood Disorders

Are there any other medical conditions not listed above that you think we should know about? (write below)

Certification of Medical History

I certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions about my medical history. I understand it is my responsibility to inform this office of changes to my medical history when they occur.

Patient (Parent/Guardian) Signature _____ Date _____

Witness _____

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We require 2 business days notice if you are unable to attend an appointment. I have been made aware and agree that failure to attend an appointment or provide at least 2 business days notice of cancellation will result in a $50.00 charge (excluding extenuating circumstances at the discretion of Banff Dental Care).

I consent to the collection, use and disclosure of my personal information and to the terms of dental treatment outlined in the "PRIVACY AGREEMENT and PATIENT CONSENT FORM for BANFF DENTAL CARE"

_____ _____
Signature Date

INSURANCE PAYMENT OPTIONS – PLEASE CHOOSE EITHER OPTION #1 OR OPTION #2

OPTION 1 – Off Assignment or Non-Insured

I agree to pay in full for treatment and get reimbursed directly by my insurance company.

Patient Signature:_____ Date:_____

OPTION 2 – On Assignment

- Once we receive payment from your insurance company, there may be a credit or debit on your account. We periodically rebalance all accounts to zero, therefore we require a credit card to be left on file.

- Insurance Companies are legally obligated to ONLY release information and send correspondence to the subscriber, making it difficult for us to assist you with your Insurance Benefits. If you choose to go "On Assignment", we require you to complete and maintain an updated Specific Power of Attorney with our office so we may communicate directly with insurance company regarding your benefits.

I, _____, authorize Banff Dental Care to keep my signature and Credit Card Number on file to issue any credit/debit memos, as well as outstanding payments, to my Credit Card account. I agree that it is my responsibility to follow up on my account status after 30 days of my visit. In the event that my credit card is declined, I agree to make alternate payment arrangements within 14 days, otherwise I consent to interest being charged on any outstanding amount at a rate of 1.5% per month (compounded monthly).

Date:_____Cardholder Name:_____Cardholder Signature:_____

Circle Card (circle): Visa/MasterCard Number:_____Expiry Date:_____

CVV2 Number (three numbers on the back of your card): _____

Specific Power of Attorney

This Specific Power of Attorney is given by me, _____, currently residing in _____, in the Province of Alberta, on the _____ day of _____, 20____.

1. I appoint Katarina Morsley and Jill Rutten of Banff Dental Care of Banff, Alberta, to jointly and severally be my Attorney in accordance with the Powers of Attorney Act of Alberta (herein referred to as my "Attorney") and in accordance with the limitations outlined in this document. It is therefore my intention that Katarina Morsley and Jill Rutten may act independently of each other.

2. This Power of Attorney shall come into effect immediately and be effective for 5 years from the date of execution.

3. My Attorney has the power to contact any company or entity providing me with, or that has provided me with, dental, medical or health insurance (including my employer) and receive, change or update any information that my Attorney considers appropriate.

4. My Attorney has the power to substitute and appoint one or more Attorney(s) under him or her with the same or more limited powers, and in his or her discretion to remove this substitute.

5. My Attorney is to be completely indemnified against all claims, actions, and costs which may arise in connection with the exercise of this Specific Power of Attorney undertaken by him or her in good faith.

DATED at the Town of Banff, in the Province of Alberta on the ___ day of _____, 20___.

SIGNED, SEALED AND DELIVERED in the presence of:)

_____)
Witness)

_____