Banff Dental Care

Please find enclosed our New Patient package, we require you to complete and email it back to us before your appointment. Please see instructions below if having trouble replying with the completed document.

iPhone Users (if this package was emailed to you):

- Open the attachment and fill in all the available fields
- Once completed click 'Done' in the top right corner
- Select "Reply All"

iPhone Users (if this package was accessed on our website):

- Open the attachment and fill in all the available fields
- Once completed select 'Share' icon  in lower menu panel
- Email us with the completed PDF attached at appointments@banffdentalcare.com

Android Users (if this package was emailed or accessed on our website):

- Open the attachment in Adobe Acrobat Reader and fill in all the available fields
- Once completed select 'Share' icon  in lower menu panel
- Share File
- Email us with the completed PDF attached at appointments@banffdentalcare.com

Laptop/Computer (if this package was emailed or accessed on our website):

- Open the attachment and fill in all the available fields
- Once completed save the document to you computer
- Email us with the completed PDF attached to appointments@banffdentalcare.com

We look forward to meeting you!

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) _____

PO Box # (if in Banff)_____ Address _____ City/Town _____Postal Code _____

Home Phone #_____ Cell #_____ E-mail _____

Gender ☐ M ☐ F Driver's License# OR SIN #_____

How did you hear about us?

□ Our Webpage	□ Employer	□ Walked-by
□ Google	□ Word of Mouth	□ Yellow Pages (Online)
□ Social Media (Facebook/Twitter)	□ Community Outreach	□ Other: _____

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

PRIMARY INSURANCE INFORMATION (if applicable):

Account Holder's Name: _____ Holder's Date of Birth (d) ___ /(m) ___ /(y) _____

Employer: _____

Insurance Carrier _____ Policy/Group# _____ ID or Certificate # _____

SECONDARY INSURANCE INFORMATION (if applicable):

Account Holder's Name: _____ Holder's Date of Birth (d) ___ /(m) ___ /(y) _____

Employer: _____

Insurance Carrier _____ Policy/Group# _____ ID or Certificate # _____

CANCELLING OR RESCHEDULING AN APPOINTMENT POLICY

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 with **no notice** will result in a $125 charge _____
Initial

- and -

Failure to provide at least 2 business days notice of cancellation will result in a $50 charge _____
(excluding extenuating circumstances at the discretion of Banff Dental Care) Initial

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

***** We direct bill to all Alberta based Insurance plans *****

OPTION 1 – Off Assignment or Non-Insured

I agree to pay in full for services rendered and get reimbursed directly (if applicable) by my insurance company.

Patient Signature:_____ Date:_____

OPTION 2 – On Assignment

***** We cannot accept VISA Debit Card or AMEX*****

- I authorize Banff Dental Care to get reimbursed by my insurance company.
- I agree to pay the out of pocket portion for services rendered, based on the explanation of benefits received from my insurance company.
- I authorize my credit card use towards any credit or debit memos on my account after Banff Dental Care receives official payment from my insurance company. (We periodically rebalance all accounts to zero, therefore we require a credit card to be left on file).
- 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 of notice, otherwise I consent to interest being charged on any outstanding amount at a rate of 1.5% per month (compounded monthly). I agree to reimburse Banff Dental Care for any reasonable legal or collection fees incurred in the course of settling of my account.

I, _____, authorize Banff Dental Care to charge my credit card when there is an outstanding balance on my account and keep my signature/Credit Card Number on file.

Date:_____Cardholder Name:_____Cardholder Signature:_____

Credit Card #:_____Expiry Date:_____

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

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MEDICAL QUESTIONNAIRE

Emergency Contact Name_____ Phone Number _____ Relationship _____

Your Physician's Name _____ Date of Last Visit _____

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

Are you currently taking any medications, including contraceptives/ supplements/ herbal medications Yes ☐ No ☐
If Yes, please list name and dosage:

Have you ever had an allergic reaction to any of the following?

☐ Latex ☐ Codeine/aspirin/ibuprofen ☐ Local anesthetic ☐ Metals ☐ Diet intolerance
☐ Penicillin ☐ Fluoride ☐ Sulfa ☐ Environmental allergy ☐ Diet allergy
☐ None ☐ Other _____

Have you ever had any of the following?

☐ 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, Adrenal disease ☐ Pulmonary (lungs) ☐ Alcohol/Drug dependent
☐ Asthma ☐ Hormonal Deficiency ☐ Viral Infections/Cold Sores ☐ Cancer
☐ Tuberculosis ☐ Diabetes (Type I or II) ☐ Hepatitis A, B or C ☐ Blood Disorders
☐ None

Do you have or have you had any other diseases or medical problems NOT listed on this form? (Please explain 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 _____
Clinical Staff Signature _____ **Date** _____

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DENTAL QUESTIONNAIRE

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): _____

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) _____

Did you ever require extra local anesthetic? Yes ☐ No ☐

What can we do to surpass your expectations? _____

AUTHORIZATION

I have reviewed the all forms presented and I have provided an accurate and complete information and have not knowingly omitted any information.

- I have reviewed the "PRIVACY AGREEMENT" and "PATIENT CONSENT FORM"
- I consent to the collection, use and disclosure of my personal and health information
- I have reviewed "Cancelling or Rescheduling an Appointment Policy"

_____ _____

Signature **Date**