Springbank Hill DENTAL

CONFIDENTIAL PATIENT RECORD

Name: _____ _____ **Sex (M/F):** _____
First Middle Last

Birth Date: _____ **Age:** _____ **Health Care #:** _____ **Prov:** _____
Year Month Day

Address: _____
Street City Province Postal Code

Phone #: _____ **Email:** _____
Home Cell

Primary Dental Insurance
Insurance company: _____
Policy/group #: _____
ID #: _____
Policyholder's name: _____
Policyholder's DOB: _____

Secondary Dental Insurance
Insurance company:_____
Policy/group #: _____
ID #: _____
Policyholder's name: _____
Policyholder's DOB: _____

How did you hear about us? Google search Walk/drive-by Community newsletter
Referred by a friend (name so we can thank them): _____
Other: _____

Medical History
Medical conditions: _____
Current medications: _____
List all allergies: _____
Do you, or have you ever smoked (circle)? Yes No If yes, for how long: _____
Are you (circle): Pregnant Breastfeeding
Do you have (circle): HIV/AIDS Hepatitis B/C A pacemaker
Is there a language barrier, or comprehension challenge that we should be aware of (circle): Yes No

Dental History
What dental conditions concern you at present: _____
When was your last dental check-up and cleaning: _____
Have you noticed any of the following (circle):
Bleeding gums Swollen gums Receding gums Loose teeth Drifting teeth
Are you aware of clenching or grinding your teeth (circle): Yes No
Have you had complications or difficulty with previous dental treatment: _____
Please rate your level of comfort at the dentist: 0 1 2 3 4 5
Completely Calm Somewhat Nervous Extremely Anxious

I certify that the medical/dental histories provided are accurate and complete to the best of my knowledge. I consent to a dental consultation and to the dental procedures that are agreed upon. I assume responsibility for the risks and costs associated with these procedures.

Signature of patient/guardian: _____Date: _____

Would you like to discuss any of these services with the Dentist/Hygienist?

- ☐ Amalgam (mercury) filling removal
- ☐ Botox Cosmetics
- ☐ Bruxism/grinding treatments
- ☐ Bleaching/whitening
- ☐ Crowns/bridges
- ☐ Correction of crooked/crowded teeth
- ☐ Cosmetic smile improvement
- ☐ Dental Implants
- ☐ Invisalign (clear braces)
- ☐ Night guards
- ☐ Replacement of missing teeth
- ☐ Snoring appliances
- ☐ Sports guards
- ☐ Veneers
- ☐ Other: _____

Dentists treat you, not your dental plan

A number of Canadians have a dental plan, but many don't realize that group plans aren't designed to meet individual health needs. Dental plans are a valuable component of extended health benefits and are designed to offset the cost of dental treatment. Understanding how dental insurance plans work can help patients make informed choices in partnership with their dentist or certified specialist.

Dentist's responsibility

Just like your physician, your dentist or certified specialist is highly trained. **Treatment recommendations are based on your dental health needs, not dictated by your dental coverage.** A dental plan is a contract between a third party (like your employer), and the insurance company. The procedures and percentages covered are determined by the contract, not your dentist.

Your dentist can help you understand your coverage and assist you in getting pre-determinations for treatment if requested. This will provide you with a good estimate of what will be covered by your plan, and what you will have to pay—before the treatment starts.

Coverage varies among dental plans

- Your dental plan coverage is part of your benefits plan, not based on your (or your family's) dental care needs.
- **Every dental plan is different.**
- Coverage varies based on what services are covered in the contract; percentage of fees covered for each service; and yearly maximums.
- It is the plan purchaser, such as your union or employer, who determines what is covered when they purchase your plan—not your dentist.
- Patient's responsibility
- Dental office staff are not experts on your plan. It is your responsibility to know your plan coverage, including any changes. Ask your benefits manager or insurance provider for a plan booklet or information on your specific coverage.

The co-payment (deductible)

Regardless of the actual costs, most dental plans cover between 50% to 80% of the cost of dental care. **Any portion of the price not covered by your plan must be paid by you, and is referred to as the co-payment** (the same as the deductible on your car or home insurance). The claim form submitted to your insurance company is a contract. Your dentist or certified specialist has an ethical and legal obligation to collect the co-payment from you.

As an added service to patients, some dental offices bill the insurance company directly for the covered portion of treatment. Dentists are not required to do this. The full cost of the procedure, including the co-payment (or deductible) or the cost of any services not covered by the plan, must be collected from the patient at the time the treatment is provided.

A dental plan is an important benefit to support good dental health. Know your plan and discuss treatment options with your dentist to make an informed decision about your dental care needs.

Be an active participant in your dental health

- **Know your dental plan and what's covered before your dental appointment to understand your portion of costs.**
- Plan for the future. Consider all your extended health costs when planning for your retirement.
- Discuss all treatment options with your dentist to make an informed decision based on your dental health needs. Understand any health risks associated with delaying or refusing treatment.
- Pay the required co-payment. You expect your dentist or certified specialist to be honest with you about the care you need, and so does the insurance company.
- Prevention is still the best treatment for everyone in your family: brush and floss daily; limit sugary drinks and snacks; don't smoke; and have an examination by a dentist at least once a year to diagnose problems before they become more complex and costly.

I have read and understand the above information and understand that knowing my insurance coverage is my responsibility prior to having any treatment rendered.

Patient/Guardian Name: _____ Date: _____

Signature: _____

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OFFICE POLICIES

Appointment Reminders

You will be reminded of your upcoming appointments with adequate time for you to make changes, if needed. However, please understand that it is ultimately your responsibility to keep track of your appointments.

Cancellations

We request a **minimum of 24 hours notice** if you wish to reschedule your appointment (48 hours notice for Monday appointments). In cases where insufficient notice is given, a fee equal to the cost of the services planned for your appointment may be charged to your account.

Direct Billing Insurance and Payment Arrangements

The Canadian Personal Privacy Act prohibits us from accessing any information from your insurance carrier. **Therefore, it is your responsibility to know the details of your plan, such as annual maximums, frequencies, and other limitations.** We extend the courtesy to bill your insurance carrier directly; however, to avoid any discrepancies, please be aware of the particulars of your plan. This will help you to maximize your dental benefits. Prior to your treatment, you may request that a "pre-determination" be submitted to your insurance carrier to give you an estimate of what will be covered prior to having the treatment done.

Below are the two payment options that are available to you. Please circle the option that you prefer:

Option 1	Payment is due in full on the day that treatment is completed. We accept cash, debit, Visa, and MasterCard. Your payment will be processed and insurance documents will be generated for you to submit to your insurance carrier. Your insurance carrier will reimburse you directly via cheque or electronic direct deposit.
Option 2	We will bill your insurance carrier directly. **You will be required to leave a credit card number on file and any outstanding amount** (i.e. any amount that is not covered by your insurance carrier) will be applied to that credit card. A receipt for payment will be provided to you.

Fee Estimates/Quotes

Any fee estimates/quotes, including insurance pre-determinations, for treatments prior to January 1st will be recognized until March 1st of that New Year. After that, any outstanding treatment estimates/quotes may change depending on the current year's fee schedule.

I have read, understood, and agree to the policies above.

_____ _____

Patient/Guardian Signature Date

Option 2 Only

I hereby authorize any outstanding balances that are not covered by my insurance carrier to be automatically applied to:

Credit Card (circle one): Visa MasterCard

Card #: _____ Expiry Date: _____(mm/yy)

CVV (3 numbers on rear of card): _____

Cardholder name: _____ Cardholder signature: _____