McKenzie Orthodontics
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Patient Information

☐ Mr ☐ Mrs. ☐ Miss ☐ Ms. ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Name ____
Last First Middle

Address: ____
City Province Postal Code

Home Phone: ________________ Cell Phone: ________________ Work Phone: ________________

Date of Birth: _________/_________/_________ Age: _________ Gender: (circle) Female Male
dd mm yy

Employer: ______________________________ Occupation: ______________________________

Email:______________________________ Spouse's Name______________________________

Are other family members patients at our office: (circle) Yes No

Would you like appointment confirmations via text messaging or email? (circle) Email Text Message

Who can we thank for your referral to our office? (please circle) ______________________________

Family Friend Brochure Newsletter Live Close By Internet Website Signage Other

Insurance Information

Name of Primary Policy Holder	Date of Birth dd/mm/yy	Primary Insurance Company	Group Policy Number	ID or Certificate Number
Patient's relationship to policy holder:	Self ☐	Spouse ☐ Child ☐	Other ☐	

Name of Secondary Policy Holder	Date of Birth dd/mm/yy	Secondary Insurance Company	Group Policy Number	ID or Certificate Number
Patient's relationship to policy holder:	Self ☐	Spouse ☐ Child ☐	Other ☐	

****Please note: Every insurance policy is different and insurance benefit booklets are guidelines only. It is the responsibility of the policy holder and patient to know your policy coverage, not the responsibility of the dental office.**

Important Contacts

In case of emergency, notify:	Relationship	Phone Number

Family Physician	Clinic Name and/or Address	Phone Number

MEDICAL HISTORY

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. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

   ❐ YES ❐ NO ____

2. When was your last medical checkup? ___________________

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. Do you have any allergies? If you answered yes, please list using the categories below:

   ❐ YES ❐ NO

   a) medications _______________________________________
   b) latex/rubber products ______________________________
   c) other, e.g hay fever, foods __________________________

6. Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain.

   ❐ YES ❐ NO

7. Do you have or have you ever had any heart or blood pressure problems?

   ❐ YES ❐ NO ____

8. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?

   ❐ YES ❐ NO ____

9. Do you have a prosthetic or artificial joint?

   ❐ YES ❐ NO

10. Have you ever been advised by your doctor to take premedication (antibiotics) before dental treatment?

    ❐ YES ❐ NO

11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy).

    ❐ YES ❐ NO ____

12. Have you ever had hepatitis, jaundice or liver disease?

    ❐ YES ❐ NO

13. Do you have a bleeding problem or bleeding disorder?

    ❐ YES ❐ NO ____

14. Have you ever been hospitalized for any illness or operations? If yes, please explain.

    ❐ YES ❐ NO ____

15. Do you have or have you ever had any of the following? Please check.

❐ arthritis	❐ pacemaker
❐ asthma	❐ prosthetic heart valve
❐ cancer	❐ seizures (epilepsy)
❐ chest pain, angina	❐ shortness of breath
❐ diabetes	❐ steroid therapy
❐ diet pill therapy	❐ stomach ulcers
❐ heart attack	❐ stroke
❐ kidney disease	❐ thyroid disease
❐ lung disease	❐ tuberculosis

16. Are there any conditions or disease not listed above that you have or have had? If so, what?

    ❐ YES ❐ NO ____

    ____

17. Do you smoke?

    ❐ YES ❐ NO

18. Does your jaw crack or pop when opened wide?

    ❐ YES ❐ NO

19. **For women only:** Are you pregnant or breast -feeding? If pregnant, what is the expected delivery date?

    ❐ YES ❐ NO ____

In order to avoid complications as a result of a change in your medical condition, it is important you notify this office of any change.

NAME:______________________________ DATE: ________

McKenzie Orthodontics

Personal Information Privacy Act

We are committed to protecting the privacy of our patients' personal information and to use all personal information in a responsible and professional manner and disclose personal information only when permitted or required by law.

Personal Information Procedures
We receive contact, medical and financial information about our patients such as names, home/work addresses, home/work phone numbers, e-mail addresses, date of birth, insurance plan details, health/dental histories, emergency contact information.

Contact information is disclosed to third party health benefit providers and insurance companies, with the CONSENT OF THE PATIENT for purposes of submission of claims, reimbursement or payment of dental care, predetermination of dental treatment, open and update patient files, invoice patients for dental services, process dental claims, and to send reminders to patients concerning the need for further dental treatment.

Medical information is disclosed, with consent of the patient, to other dentists, dental specialists, or health care professionals such as physicians. It is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Financial information is collected for payment processing purposes. It is not shared with third parties unless permitted by law for outstanding bill collection purposes.

Insurance Policy Matters

I am aware that South Family Dental does not accept assignment from my insurance company. The dental office accepts **no responsibility** for any uncovered amounts, amounts over allowed benefit maximums, plan limitations or restrictions, etc. McKenzie Orthodontics has advised me that I make myself aware of my dental plan and know my coverage. My dental insurance policy is an agreement between me and my insurance company. The insurance company does not permit releasing any information to the clinic due to the Health Privacy Act. We want to make you aware of this fact. Dental providers usually receive payments four weeks after treatment and sometimes longer if you have more than one insurance plan. **Please note that every insurance policy is different. It is the responsibility of the policy holder and the patient to know your policy coverage. It is NOT the responsibility of the dental office.**

Please remember that under no circumstance is it customary for an insurance company to cover a dentist's fee in full. Our fees are reasonable and competitive according to Alberta Dentists Association Standards. **You are responsible for payment regardless of your insurance company's determination of the amount.**

Please keep track of you yearly maximums, limitations, appointment dates and accumulated amounts used on your dental plan. McKenzie Orthodontics has advised me to contact my plan provider should I have any questions.

Thank you for understanding our policy. Please let us know if you have any questions.

I consent to the collection, use and disclosure of my personal information as set out above and that of my dependents. I authorize McKenzie Orthodontics to keep my signature on file to charge any credit/debit memos, as well as outstanding payments in the event of short-notice cancellation/missed appointment and remaining balances after my insurance claims have been paid, to my credit card. I agree to keep McKenzie Orthodontics updated with a current credit card and inform of any changes in my insurance following treatment. This credit card information will be kept on a separate confidential file that is secure. A receipt will be emailed to you if provided.

Signature of Patient: ____ Date: _______________________