PERSONAL INFORMATION

Today's Date:_____

Name: (Last)_____(Given)_____(Initial)_____

Date of Birth: (day/month/year)_____Age: _____Male:_____Female:_____

Home Address: _____

City: _____Postal Code:_____Email Address:_____

Phone/Home: _____Business:_____Cell:_____

How did you hear about our office?_____

Alberta Health Care Number:_____Occupation:_____

Dental Insurance

(If for child and dual please list parent born first in the year)

Primary / Name of insurance company: _____

Group/Policy #:_____Certificate Id#:_____

Policy holder (first/last)name:_____DOB:_____

Employer:_____

Secondary / Name of insurance company: _____

Group/Policy #:_____Certificate Id#:_____

Policy holder (first/last)name:_____DOB:_____

Employer:_____

PERMIT FOR OPERATIONS

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of the local anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's Signature: _____

Parent's Signature (if under 18yrs of age): _____

Railway Avenue Dental Medical History

Although dental personnel primarily treat the area in and around your mouth, it is also a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes	O No	If Yes _____
When was the last time you had a medical examination?	O Yes	O No	Date: _____
Are you presently receiving treatment for any illness?	O Yes	O No	If Yes _____
Have you ever been hospitalized or had a major operation?	O Yes	O No	If Yes _____
Have you ever had a serious head or neck injury?	O Yes	O No	If Yes _____
Do you have any heart or circulatory problems?	O Yes	O No	If Yes _____
Do you have a pacemaker?	O Yes	O No	If Yes _____
Have you ever had rheumatic fever? When?	O Yes	O No	If Yes _____
Are you taking any medications, pills or drugs? If Yes, please specify the drug, dosage (if known) and reason for taking it.	O Yes	O No	If Yes _____ _____
Do you take, or have you taken Phen-fen or Redux?	O Yes	O No	If Yes _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes	O No	
Are you on a special diet?	O Yes	O No	
Do you smoke, vape, or use chewing tobacco? How much per day? How much per week?	O Yes	O No	Per day _____ Per Week _____
Do you use controlled substances?	O Yes	O No	
Have you ever been advised to take antibiotic pre-medication prior to dental treatment?	O Yes	O No	
Do you have food or seasonal allergies? Please specify.	O Yes	O No	_____

Female Patients, are you:

O Pregnant? O Breastfeeding/Nursing O Taking oral contraceptives?

Do you have any allergies to the following?

O Aspirin O Acrylic O Codeine O Latex
O Local Anesthetic O Metal O Penicillin O Sulfa Drugs
O Other: _____

Do you have, or have you had, any of the following?

- O Acid Reflux/Gerd
- O AIDS/HIV
- O Alcohol or chemical dependency
- O Anemia
- O Angina
- O Arthritis/Gout or Rheumatism
- O Artificial Joints or Valves
- O Asthma
- O Alzheimer's Disease
- O Blood Transfusion
- O Blood Disease
- O Breathing Problems
- O Bruise easily
- O Cancer
- O Chemotherapy
- O Chest Pain
- O Cold Sores/Fever Blisters
- O Congenital Heart Disorder
- O Convulsions
- O Cortisone Medication
- O Diabetes
- O Drug Addition
- O Eating Disorders
- O Easily Winded
- O Emphysema
- O Epilepsy/Seizures
- O Excessive Bleeding
- O Excessive Thirst
- O Fainting/Dizzy Spells
- O Frequent Cough
- O Frequent Diarrhea
- O Frequent Headaches
- O Genital Herpes
- O Glaucoma
- O HayFever
- O Heart Attack/Failure
- O Heart Murmur
- O Heart Trouble/Disease
- O Hemophilia
- O Hepatitis A
- O Hepatitis B or C
- O High Cholesterol
- O High Blood Pressure
- O Hives or Rash
- O Hyper/Hypoglycemia
- O Irregular Heartbeat
- O Kidney Disease
- O Leukemia
- O Liver Disease (Hepatitis/ Jaundice)
- O Low Blood Pressure
- O Lung Disease/Chest Pains
- O Mental or Nervous Disorder
- O Mitral Valve Prolapse
- O Multiple Sclerosis
- O Osteoporosis
- O Pain in Jaw Joints (TMD)
- O Parathyroid Disease
- O Psychiatric Care
- O Radiation Treatments
- O Recent Weight Loss
- O Renal Dialysis
- O Scarlet Fever
- O Shingles
- O Sickle Cell Disease
- O Sinus Trouble
- O Spina Bifida
- O Stomach Ulcers
- O Stomach/Intestinal Disease
- O Stroke
- O Swelling of Limbs (Lymphedema)
- O Thyroid Disease
- O Tonsilitis
- O Tuberculosis
- O Tumors or Growths
- O Ulcers
- O Venereal/Communicable Disease
- O Yellow Jaundice

Do you have any serious illness/disorder or allergy not previously listed? If yes, please provide additional details.

_____

_____

Do you grind or clench your teeth?	O Yes	O No
Do you suffer from any of the following:		
Headaches?	O Yes	O No
Earaches?	O Yes	O No
Neck aches?	O Yes	O No
Sore/tender facial muscles?	O Yes	O No

Is there any additional information related to your health that has not been addressed previously?

_____

_____

_____

I, the undersigned, have completed the above questionnaire and/or update and I confirm that it is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Parent or Guardian: _____ Date: _____

Patient Name: _____ Date of Birth: _____

RAILWAY AVENUE DENTAL

114, 85 Railway Avenue SW, Airdrie AB, T4B 3W9 TEL: 587-360-3062 FAX: 587-360-3067
EMAIL: info@railwayavenuedental.ca www.railwayavenuedental.ca

PRIVACY, DISCLOSURE & CONSENT

PRIVACY ACT & CONSENT TO TREATMENT

By signing this form, you acknowledge and agree that you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Act. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of RAILWAY AVENUE DENTAL to provide the services you are requesting.

ACKNOWLEDGEMENT REGARDING INFORMATION PROVIDED

I, the undersigned, certify that I have provided an accurate and complete personal, medical and dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical & dental history. Should there be any change in either my health status or any other information I have provided, I will advise RAILWAY AVENUE DENTAL. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among RAILWAY AVENUE DENTAL, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by RAILWAY AVENUE DENTAL in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that RAILWAY AVENUE DENTAL is relying upon the information which I have provided being accurate and complete.

_____ _____ _____

Print Name of oPatient oParent o Guardian Signature of oPatient oParent o Guardian Date

_____ _____

Reviewed by RAILWAY AVENUE DENTAL Date

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WELCOME TO RAILWAY AVENUE DENTAL!

Thank you for selecting us as your personal dental team. We are very proud of our knowledgeable, well trained, and caring dental team. You will find us dedicated to maintaining optimum oral health.

Please take a minute to familiarize yourself with some of our office procedures and policies.

- Every effort is made to provide adequate notice for upcoming appointments, and confirmation responses. If you are unable to keep your appointments, and changes are required, please **DO NOT** use email, or a text message to cancel or reschedule your appointment. We require you speak directly to one of our treatment co-coordinators in order to accommodate your request, **as we are unable to accept or respond to these types of scheduling changes via e-mail or text message.**
- No charge will be made for rescheduling an appointment, providing 2 working days notice is given; otherwise a charge will be incurred. Once an appointment has been made, please remember that this time is reserved specifically for you.
- Dental Insurance is a contract between you and your insurance company. As a courtesy, we will accept assignment on your behalf and/ or prepare and submit a predetermination if required. Because of the privacy act we are not privy to the terms and restrictions of your plan (ie. yearly maximum and benefit year, recall frequency, units of scale), therefore you are responsible for any money owing which your dental plan does not cover.
- In order to accept assignment from your dental plan, we require an imprint and signature of a current and valid credit card. Payment is required at time of service for any amount not covered by your plan. If we do not know your balance the day you are in for your dental services we will utilize your credit card once we receive payment from the insurance provider. As a courtesy, If the amount is over $100 we will notify you. Either way you will receive a receipt by mail or email.
- Assignment is not accepted with regards to specialty services; ie: orthodontic treatment, dental implants.

Your Financial Consent

The patient/or guardian agrees to be fully responsible for total payment of procedures performed in this office for any treatment NOT covered by the dental insurance.

I certify I have read and understood the above.

Today's Date: _____

Patient/Guardian Signature:

Sign: _____ Print: _____

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What to expect at your Complete Exam and Hygiene Appointment:

The first appointment at Railway Avenue Dental consists of a complete exam and a hygiene appointment. Most of the time these two are performed on the same day. A complete exam entails a full examination of the oral tissue, teeth, tongue, temporomandibular joint (TMJ), and certain structures in the neck. A full record of the existing dentition is created, which involves charting existing and missing teeth, any restorations that are present, and any treatment that needs to be completed. In order for the dentist to properly diagnose cavities, certain types of x-rays are required. An oral cancer screening is performed as well.

At the hygiene appointment, scaling will be performed to remove the build-up from under your gums, and off of the tooth itself. A polish will remove any accumulated plaque and stain, and will smooth certain rough areas. Also, at the discretion of the patient, and/or recommended by the hygienist, an application of Fluoride will be provided to strengthen any weakened areas of tooth structure.

The typical fees and service codes are as follows:

Type of Service for Complete Exam Appointment	Service Code	Fee for Service
Complete Exam – Permanent (Adult are present)	01103	$116.66
Complete Exam (Mixed) (A mixture of baby and adult teeth are present)	01102	$111.51
Complete Exam (Primary) (Baby teeth are present)	01101	$81.82
Up to, and Including 4 Bitewing X-rays (To check for cavities between the teeth)	02144	$100.36
Up to, and Including 3 Periapical X-rays	02113	$77.48
Panorex X-Ray (To check for abnormalities within the facial structure/joint)	02601	$101.53

Type of Service for New Patient Hygiene Appointment		
Up to, and including 3 units of Scaling – billed in units of time (15 minutes = 1 unit of scaling. $70 per unit)	11113	$231.63
Polishing (Prophy) (Polishing of teeth to remove stain)	11101	$68.34
Fluoride Treatment	12101	$33.33

Please note: Fees associatied with the services listed above may change without notice.

INSURANCE:
Insurance coverage for the services listed above **will vary** with each individual insurance plan, and is based on a contract between You (the Patient or Guarantor), & your Insurance Company. We advise all of our New Patients who book for any of the above services, to know all of the coverage details and restrictions prior to attending your appointment. If you are unsure of coverage, we strongly advise you contact your insurance company directly to discuss your policy details with them. Due to the Privacy Act, our office is not entitled to any of the details regarding what your insurance company may, or may not consider coverage for.

If the insurance company denies payment for any of the above services due to restrictions placed on a service, it is the Account Holder's responsibility to ensure full payment of that service at the time of your appointment.

Patient or Guarantor's Signature _____ Date: _____

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Request for Dental Records

Office we're requesting records from: _____
Phone Number: ( )_____

Please provide copies of the following records:

_X_ Bitewing radiographs within the last year

_X_ Panorex radiograph within the last 5 years

____ Other:_____

____ Include records for myself only

____ Include records for family members

Patient consent:

I, _____, authorize the release of the above mentioned records to Railway Avenue Dental.

Date: _____

Patient Name (please print): _____

Other Family Members: _____

Signature: _____

Please forward records to:

Email to: jf@railwayavenuedental.ca

Or
Mail to:
Railway Avenue Dental
Unit #114, 85 Railway Avenue SW
Airdrie, AB T4B 3W9