VIC WEST DENTISTRY

Welcome to our Office

Last name	First	Preferred	Mid	Title	Sex
Date of Birth	Physician		Account Holder		
Address		City			
Province		Postal Code		Employer	
Home Phone	Cell		Email		
How did you hear about us?					
If under 18, name of Parent/Guardian					

Is another member of your immediate family or relative a patient in our office? Y / N

Medical History

Circle any of the following which you have had or have at the present:

Heart failure	Chronic Fatigue	Emphysema	Heart Disease or attack
Fibromyalgia	Blood Transfusion	Angina Pectoris	Glaucoma
Hemophilia	Stroke	Ulcers/Acid Reflux	Epilepsy or Seizures
Heart murmur	Cancer	Mental/Nervous Disorder	Heart Pacemaker
Chemotherapy	Radiation	Behaviour Disorder	Heart Surgery
AIDS/HIV positive	Eating Disorder	Congenital Heart Lesions	Hepatitis A(infectious)
Psychiatric Treatment	Artificial Heart Valve	Hepatitis B(serum)	Hepatitis C
Fainting or dizzy spells	Artificial Joint	Liver Disease	Cold Sores
High Blood Pressure	Low Blood Pressure	Yellow Jaundice	Sinus Troubles
Kidney Problems	Sickle cell disease	Allergies or Hives	Asthma
Rheumatic Fever	Use of Tobacco	Diabetes	Scarlet Fever
Treatment of Alcohol	Thyroid Disease	Anaemia	Drug Addiction
Hyper/Hypo Glycaemia	Stomach/Intestinal	Bruise Easily	Arthritis/Rheumatism
Tuberculosis	Depression		

Is there a disease, condition or problem not listed?	Yes	No
Have you been a patient in the hospital the past two years?	Yes	No
Have you been under the care of a medical doctor during the past two years?	Yes	No
Are you or have you been under the care of a naturopathic/alternative treatment	Yes	No

Are you allergic to any medications?

Which?_____

Are you taking any medications including tranquilizers, sedatives, or herbals (Please list)?
Taking_____for_____
Taking_____for_____

When you walk upstairs or take a walk, do you have to stop because of pain in your chest, or shortness of breath, or because you are very tired? Yes No

Do your ankles swell during the day? Yes No

Following injuries, have you ever had a bleeding problem? Yes No

Women are you practicing birth control? Yes No

Are you pregnant (due date) _____or anticipate becoming pregnant? Yes No

Dental History

Have you ever had any of the following?

Periodontal Treatment? (treatment of the gums) Yes No

Orthodontic Treatment? (to straighten or realign teeth) Yes No

A bite plate or any other special appliance? Yes No

Your bite adjusted or teeth ground? Yes No

Oral Surgery Yes No

Have you ever experienced any of the following jaw problems?

Popping	Clicking	Pain in your jaw	Pain in your ears
Difficulty Opening	Difficulty Closing	Pain when clenched	Pain when chewing

Do you feel very nervous/anxious about having dental treatment? Yes No

Do your gums bleed when brushing your mouth? Yes No

Are you unhappy with the appearance of your teeth? Yes No

And, what would you like to see changed?_____

Do you have any specific concerns about dental treatment?

_____

Date of last dental exam?_____

Reason for today's visit?_____

Consent

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 general or local anaesthetics as indicated and I will assume responsibility for fees associated with those procedures. You will be requested to pay at each appointment.

_____ _____

Patient Signature (or Guardian if under 18) Date

Dental Insurance

In the matter of the personal information protection and electronic documents act. I authorize release, to my dental benefits plan administer and CDA, information contained in claims electronically. I herby assign my benefits, payable from claims submitted electronically submitted to Vic West Dentistry and authorize payment directly to them. This authorization shall continue in effect until the undersigned revoked the same.

_____ _____

Patient's Signature (or Guardian if under 18) Date

Please provide the front office staff with a copy of your insurance identification card or printout with your plan information.

Privacy, Disclosure and Consent

Information for our Patients

At Vic West Dentistry, all professional dental services are performed by licensed members of the College of Dental Surgeons of British Columbia ("Dental Professionals"), and all institutional health care services are performed independently by Vic West Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Vic West Dentistry and Vic West Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective serviced. One or more of our Dental Professionals may have a financial interest in Vic West Health Services.

Privacy Act and Consent to Treatment

By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have had the opportunity to request a copy of the Privacy Code for Vic West Dentistry; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. 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 Vic West Dentistry to provide the services you are requesting.

Acknowledgement regarding Information Provided

I, the undersigned, certify that I have provided an accurate and complete personal and medical- 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 this dental office. 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 Vic West Dentistry, Vic West Health Services, my medical doctor, and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code, have had the opportunity to request a copy. I acknowledge that my personal information will be collected, used, and disclosed withing the guidelines of the Privacy Code. I also understand that my personal information will be retained by Vic West Dentistry and in accordance with their current practices. I, the undersigned, acknowledge that the Vic West Dentistry and Vic West Health Services are relying upon the information which I have provide being accurate and complete.

_____	_____	_____	_____
Patient name	Patient Signature	Witness	Date

_____

Reviewed by Vic West Dentistry

Settlement and Insurance Agreement

Dental Plan coverage is intended to assist patients in their dental care. It is not intended to cover all aspects of care. Our dental office provides assignment of insurance for our regular patients to most insurance companies as a courtesy. Due to the Privacy Act legislation, the dentist is considered to be a third party. Therefore, we may be unable to gain information about your coverage. This may affect our ability to know the limitations of your policy.

Thus, it is especially important for you to be completely familiar with and advise us of your dental coverage, deductibles, dollar limits, hygiene restrictions, and any changes throughout our partnership.

Your Responsibility

In a case of dental insurance non-payment or partial non-payment, you will be responsible for any outstanding amount. Some insurance carriers send pre-authorizations and/or payment directly to the policy member (you the patient). If the insurance company deals directly with you, full payment for all treatments rendered is expected at the time of treatment. Any pre-authorizations sent to you must be forwarded to our office.

If we are able to submit claims for direct payment (to our office), we will work with your insurer for up to 60 days to collect payment. Any amounts unpaid after 60 days will be re-allocated to your account and be due immediately. Interest is accumulated on any accounts older than 60 days.

Our Fees

Our fees are above the current College of Dental Surgeons of British Columbia Fee Guide reflecting the high level of care, skill and judgement exercised by our practitioners. Fees are increased February 1st of each year. All insurance benefit plans, however, have their own fee schedule, maximum amounts, and limitations. **The difference in any fees is your responsibility and payment of balance is due at the time of treatment.**

Any appointments cancelled or changed within 2 business days of the scheduled time may incur a cancellation fee at the discretion of the practice unless due to extreme circumstances or illness. This fee would not be covered by insurance.

Our Estimates

Our estimates are valid for 90 days. By proceeding with any treatments provided by our office you are agreeing to unforeseen associated costs, limitations, and restrictions outlined in your dental policy agreement. **Our estimates are based on the information you provide and are limited by that. It may not be the final fee.**

Patient Responsibility

I have read, understood, and accepted the terms above. I will assume the responsibility for fees associated with those procedures provided, in accordance with the terms described above.

_____	_____	_____	_____
Patient name	Patient Signature	Witness	Date