Bridlewood Dental Clinic

#203, 2335 – 162nd Ave. SW, Calgary, AB T2Y 4S6

403-201-6999

PERSONAL INFORMATION:

Last Name: First Name:

Preferred/Nickname: Date of Birth day/mo/yr Gender: M / F

Address: City:

Province: Postal Code: Email:

Home Ph: Work Phone: Cell Phone: Other:

How did you hear about our office & whom may we thank for referring you? ______________________________

Billing & Financial Responsibility:

Complete Name: ______________________________ Gender: M/F Date of Birth: ______________
Address: ____
City: __________________ Province: ________________ Postal Code: ________________
Relationship (circle): Self, Spouse//Partner, Parent, Other: ________________

*****You are responsible for YOUR portion of payment that is NOT covered by Insurance on Date of service.*****

Dental Benefits:

Primary Insurance:
Policy Holder Name: ________________ Employee's DOB: ___________
Insurance Company: ______________________
Subscriber ID #:________________ Group/Plan/Policy #:____________
Relationship: Self, Spouse/Partner, Parent, Other: ______________

Secondary Insurance:
Policy Holder Name: ________________ Employee's DOB: ____________
Insurance Company: ______________________
Subscriber ID #:________________ Group/Plan/Policy #:____________
Relationship: Self, Spouse/Partner, Parent, Other: _______________

***As per the privacy Act:** Your dental plan information is considered "confidential, medical information" and as such it will not be released to us, as your dental care provider. Any questions regarding your insurance or coverage should be directed to your insurance company. It is important that you are familiar with your dental plan before treatment in order to eliminate any disappointments with coverage and reimbursement. Your benefit coverage is a contract between yourself, your employer and the insurance company.*

ALLERGIES:

Circle any medication &/or substances that you are allergic to, or have ever experienced any adverse reaction to & please give details of such:

Penicillin Tetracycline Codeine Aspirin Sulfa Drugs Latex Local Anesthetic

L**ist any other** medications &/or substances that your are **allergic** to, or have ever experienced any adverse reaction to:____________________

MEDICATIONS:

List all current medications (BOTH OVER-THE COUNTER & PRESCRIPTION), supplements (HERBAL & DIETARY AIDS), &/or recreational substances that you are **currently** taking, &/or use on a regular basis:____________________

HEALTH CONDITIONS:

Circle any health conditions which apply to you:

Anemia	Other Mental Illness	VD, or other STD's
Arthritis	Epilepsy/Seizures	HIV, or AIDS
Artificial Prosthetics	High/Low Blood Pressure	Asthma/Respiratory Issues
Cancer/Tumor/Growth	Heart Attack/Stroke	Glaucoma
Diabetes	Other Cardiovascular Conditions	Kidney Disease
Depression	Hepatitis (type:____)	Liver Disease

Circle any additional health issues which apply to you:

Bleeds Easily	Frequent Headaches	Stomach/Digestive Problems
Prone to Fainting	Grinding/Clenching	Drug & / or Alcohol Abuse
Seasonal Allergies	Chronic Dry Mouth	Cigarette Smoker
Sinus conditions	Snoring/Sleep Apnea	N/A (if have no medical issues)

List any additional health information/conditions:____________________

For our female Patients (of reproductive age):

Are your currently pregnant? Y/N	Due date:____________________
Are you trying to become pregnant? Y/N	Are you currently breastfeeding? Y/N
Are you taking oral contraceptives? Y/N	Are you taking any hormone medications?

MISSED APPOINTMENTS: In order to be fair to all patients, we ask that you notify our office at least 48 hours in advance should you have a conflict with your appointment time. Failure to contact the office will result in a charge of **$90/hour** reserved for the missed appointment(s).

FINANCIAL AGREEMENT: We ask that you read and sign this statement prior to your first treatment. For extensive treatment plans, we may be able to offer extended payment plans with written approval of the clinic manager and on approved credit. We accept cash, debit, as well as ALL MAJOR CREDIT CARDS (Visa, MasterCard), personal cheques are not accepted. The ultimate responsibility for all services rendered, and their associated fees, remain with each patient at all times. I understand that my account will be assigned automatically to a collection agency **if there is any unpaid balance after 60 days.** I will pay **ALL** cost of collection: any additional steps required to collect my account, including court cost and attorney's fees incurred by Bridlewood Dental. **(We require a Credit Card number for ALL patients to be kept on file)**

I have read and completely understand all statements in the above agreement.

Signature of Guardian if patient under 18 years of age. ____________________

Signature:____________________ **Name:**____________________ **Date:**__________

Credit Card Authorization

Please keep my signature on file to acknowledge that I have authorized Bridlewood Dental to charge my credit card automatically for any estimated patient portion due at the time of service, as well as for any remaining balance after insurance payment is received. If insurance has not paid within 30 days, you may also bill my credit card automatically for the full amount of my outstanding balance, and I will deal with my insurance directly.

Bridlewood Dental will mail receipts to my home address for all automatic credit card transactions. I understand that Bridlewood Dental's billing to my insurance does not change my ultimate responsibility for all services rendered and their associated fees.

Should my credit card be declined for any reason, I understand that Bridlewood Dental will attempt to contact me by phone. At that time, my balance must be paid within 1 week by another method. If full payment is not made within one week, or if Bridlewood Dental cannot contact me by phone, I understand that my account will be assigned to a collection agency.

Name of Card Holder: ______________________ Card Type: VISA MasterCard

Credit Card Number: ______ - ______ - ______ - ______ Exp.: ________/________

3-Digit Security Code: ________

Home Tel: ______________________ Office/Cell. Tel: ______________________

I have read and do understand all content of this, Part III *Agreement for Assignment of Benefits from a Third Party*.

Patient/Guardian Printed Name: ______________________________

Signature ______________________ **Date:** day month year