# COCHRANE DENTAL CENTRE
## Dr. David B. Sawka & Associates

*The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimum oral health.*
*Please fill out this form completely. The better we communicate, the better we can care for you.*

## 1 *About You*

Today's Date ______________________

Your Name: ______________________
Last First Initial

I prefer to be called: ____________ ❐ Male ❐ Female

Birthday ____/____/____ Age ______
Month Day Year

Home Address ______________________

______________________
City Postal Code

Home Ph: #: __________ Cell Ph #: __________

Work Ph: #: ______________ Ext: ______

What number is best to reach you: ❐ Home ❐ Cell ❐ Work

E-mail: ______________________

**Appointment Confirmation Preference**
**❐ E-Mail ❐ Text Message**

Employer: ______________________

Occupation: ______________________

When and where are the best times to reach you? __________

______________________

Who may we THANK for referring you? __________

Other family members seen by us: __________

______________________

## 2 *About Your Spouse*

Your Name: ______________________
Last First Initial

Employer: ______________________

Work Ph: #: ______________ Ext: ______

## IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Their Name: __________ Relation: __________

Work Ph #: __________ Home Ph #: __________

## 3 *Your Dental Insurance*

### Primary Dental Insurance

**Insured's Name:** ______________________
Last First Initial

Birthdate of Insured: ______/______/______
Month Day Year

Relation: ______________________

Employer: ______________________

Insurance Co. Name: ______________________

Group # ____________ Div. #: ____________

Certificate #:: ______________________

**Coverage** Basic%______ Major %______ Yearly Max: ______

What restrictions do you have on your dental insurance?

______________________

______________________

eg. How many units of scaling are covered?
How often does your plan cover a dental examination?

### Secondary Dental Insurance

Insured's Name: ______________________
Last First Initial

Birthdate of Insured: ______/______/______
Month Day Year

Relation: ______________________

Employer: ______________________

Insurance Co. Name: ______________________

Group # ____________ Div. #: ____________

Certificate #:: ______________________

**Coverage** Basic%______ Major %______ Yearly Max: ______

What restrictions do you have on your dental insurance?

______________________

______________________

*Thank you for filling out this form completely. It enables us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help!*
*Our office is committed to exceeding the standards of infection control mandated by OHSA, the CDA and the ADA.*

# COCHRANE DENTAL CENTRE
## Dr. David B. Sawka & Associates

Please tell us what you require for today's visit:

- ❑ Full mouth examination and treatment plan.
- ❑ Specific problem only.

Are you having any pain or discomfort at this time? ❑ Yes ❑ No

Have you ever had a complication with past dental work? ❑ Yes ❑ No

On a scale of 1 - 10 (1 being not nervous at all, 10 extremely nervous to just sit in the chair).

please rate your comfort with dental appointments _______.

What can we do to make your visit more comfortable? ____________________

Who was your previous dentist?____________________ Approximate date of last appointment ____________________

**Please check if any of the following apply to you:**

| | | | |
|---|---|---|---|
| Teeth that are sensitive to heat or cold | ❑ | Food getting stuck between your teeth | ❑ |
| Teeth sensitive to sweets | ❑ | Gums that bleed or feel tender when you brush or floss | ❑ |
| Teeth sensitive to biting pressure | ❑ | Frequent cold sores, canker sores or any other mouth sores | ❑ |
| Broken fillings or rough edges on teeth | ❑ | Did you ever experience a skin reaction to jewellery or watches | ❑ |

| | | |
|---|---|---|
| Are you aware of grinding or clenching your teeth? | Y | N |
| Does chewing gum bother your jaw? | Y | N |
| Are you aware of any popping, clicking or grinding noises when you move your jaw? | Y | N |
| Do you suffer from chronic headaches or chronic pain in the neck or back? | Y | N |
| Have you ever had injury to the chin, face or head or been in a motor vehicle accident? | Y | N |

| | | |
|---|---|---|
| Do you think your teeth are worth keeping for a lifetime? | Y | N |
| If you could safely whiten your teeth, would you be interested? | Y | N |

Is there anything you would like to change about your smile?

____________________

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

____________________ ____________________

Signature of Patient Date

I verbally reviewed the medical and dental information above with the patient herein. ____________________

## WELCOME TO COCHRANE DENTAL CENTRE

Today's Date: ______________________

NAME: ______________________ BIRTH DATE: ____________ ☐M ☐F
ADDRESS: ______________________ POSTAL CODE: ______________________
CITY: ______________________ WORK PHONE: ______________________
HOME PHONE: ______________________ EMERGENCY CONTACT: ______________________
CELL PHONE: ______________________ EMERGENCY CONTACTS PH#: ______________________

**PLEASE PROVIDE CONTACT INFORMATION FOR YOUR FAMILY PHYSICIAN:**

NAME: ______________________ PHONE: ______________________

## MEDICAL HISTORY FORM:

| Condition | | Details of Specified Condition | Notes (office use only) |
|---|---|---|---|
| Anaemia | Yes☐ No☐ | | |
| Angina | Yes☐ No☐ | | |
| Anorexia/Bulimia | Yes☐ No☐ | | |
| Artificial Joints | Yes☐ No☐ | | |
| Asthma | Yes☐ No☐ | | |
| Bleeding Disorder | Yes☐ No☐ | | |
| Cancer | Yes☐ No☐ | | |
| Chronic Pain | Yes☐ No☐ | | |
| Cortisone/Steroid Treatment | Yes☐ No☐ | | |
| Depression/Anxiety | Yes☐ No☐ | | |
| Diabetes (Type I/II) | Yes☐ No☐ | | |
| Drug/Alcohol Abuse | Yes☐ No☐ | | |
| Emphysema | Yes☐ No☐ | | |
| Epilepsy/Seizures | Yes☐ No☐ | | |
| Fainting | Yes☐ No☐ | | |
| Glaucoma | Yes☐ No☐ | | |
| Head/Neck Radiotherapy | Yes☐ No☐ | | |
| Heart Attack/Stroke | Yes☐ No☐ | | |
| Heart Defect/Valve | Yes☐ No☐ | | |
| Heart Murmur | Yes☐ No☐ | | |
| Hepatitis (A,B or C) | Yes☐ No☐ | | |
| High Blood Pressure | Yes☐ No☐ | | |
| HIV/Immunocompromised | Yes☐ No☐ | | |
| Hypoglycemia | Yes☐ No☐ | | |
| Kidney Disease | Yes☐ No☐ | | |
| Leukemia | Yes☐ No☐ | | |
| Liver Disease | Yes☐ No☐ | | |
| Osteoporosis | Yes☐ No☐ | | |
| Pacemaker | Yes☐ No☐ | | |
| Rheumatic/Scarlet Fever | Yes☐ No☐ | | |
| Rheumatoid Disease | Yes☐ No☐ | | |
| Surgeries | Yes☐ No☐ | | |
| Sinus Problems | Yes☐ No☐ | | |
| Thyroid Disease | Yes☐ No☐ | | |
| Tuberculosis | Yes☐ No☐ | | |
| Ulcers/Colitis | Yes☐ No☐ | | |
| STD / STI | Yes☐ No☐ | | |

## ALLERGIES

Are you **allergic** to the following?

| Medication | | Details/Date | Medication | | Details/Date |
|---|---|---|---|---|---|
| Penicillin Antibiotics (including amoxicillin) | Yes☐ No☐ | | Nitrous Oxide | Yes☐ No☐ | |
| Latex (dental gloves) | Yes☐ No☐ | | Local Anesthetics | Yes☐ No☐ | |
| Codeine<br>Erythromycin | Yes☐ No☐<br>Yes☐ No☐ | | Sulpha Drugs<br>Nickel | Yes☐ No☐<br>Yes☐ No☐ | |
| Aspirin | Yes☐ No☐ | | Iodine | Yes☐ No☐ | |

## MEDICATIONS

Please list **all medications** you are taking below:

| Medication | Date | Dosage | Condition Treated/Further Details |
|---|---|---|---|
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## LIFESTYLE

Do you **smoke**: Yes☐ No☐
If so *how much*: ______________________

Do you chew **tobacco**: Yes☐ No☐
If so *how often*: ______________________
*Where in the mouth* do you place it? ______________

## FOR WOMEN ONLY

Are you pregnant? Yes☐ No☐
Are you nursing? Yes☐ No☐

Due Date ______________________
Until? (estimated) ______________________

## SIGNATURE

I hereby certify that the information disclosed in this medical history form is accurate to my knowledge

Name: ________________ Signature: ________________ Today's Date: ________________

Dr. David B. Sawka & Associates

Dental Office Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses (collectively referred to as "Contact Information"). Contact Information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment.
- To send patients informational material about our dental practice.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. (Collectively referred to as "Medical Information") Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other dentists and dental specialists if the patient has been referred by us to the other dentist or dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

***I consent to the collection, use and disclosure of my personal information as set out above.***

| ____________ | ____________________ | ____________________ |
|---|---|---|
| *Date* | *Print name* | *Signature* |

# Cochrane Dental Centre Office Policies

**Appointment Reminders**

Please understand that it is your responsibility to keep track of your appointments. We will do our utmost to ensure you receive reminders, and have adequate time to make arrangements or change your appointments.

**Cancellations**

We require a minimum 24 hours' notice to modify your scheduled appointments, and 72 hours' notice for MONDAY appointments. The appointments are valuable time that has been reserved for you with our Dentists/Hygienists. In the event that insufficient notice is given, a charge (fee) of **$55** may be applied to your account.

**Direct Billing Insurance Companies & Payment Arrangements**

The Canadian Personal Privacy Act prohibits us from accessing information from most insurance carriers. As every policy is unique, it is your responsibility to know the details of your particular plan *(especially annual maximums & frequency limitations)*. We do offer direct billing to insurance as a courtesy, and will submit pre-determinations (estimates) for major treatment, however it is important that you understand the details of your policy to utilize your benefits to their maximum and avoid any discrepancies.

**I have read the above information and understand and accept the Cochrane Dental Centre office policies.**

Signature: ______________________________ Date: ______________________________

**Below are 2 payment options available to you (& your account). Please CIRCLE the option you would like to participate in.**

Option 1 — Payment is due in full on the day the treatment is completed. We accept Cash, Debit, MasterCard, Visa & AMEX. Your payment will be processed and your insurance documents will be generated and submitted to your insurance carrier; where upon your insurance carrier will reimburse you directly.

Option 2 — We will direct bill your insurance carrier. If we receive an explanation of benefits from your insurance carrier following your visit, the outstanding balance will be collected before you leave. If you select this Direct Billing option, you will be required to leave a CREDIT CARD on file. If there is a balance on your account following your insurance company paying Cochrane Dental Centre, this balance will be charged to the Credit Card on file and a receipt for payment will be emailed to you. **A credit card is not required for any Government Sponsored Insurance plans (ie Alberta Works).**

Direct Billing is a courtesy we offer to our patients and in order 'Direct Bill' your insurance provider, we require a credit card on file or any outstanding amounts owing after your insurance provider has paid their portion. Outstanding account balances over 60 days will be charged 2% interest monthly.

I hereby agree to the Financial Policy of Cochrane Dental Centre as outlined above, and authorize Cochrane Dental Centre to apply any outstanding balance on my account that is not covered by my insurance provider to the credit card listed below:

**PAYMENT OPTIONS ARE AS FOLLOWS:**

☐ **VISA** ☐ **MASTERCARD** ☐ **AMEX**

**Card #:**______________________________ **EXP Date:**______________ **CVV:**__________

**Name on Card:** ______________________________

**Authorized Signature:** ______________________________