For the Personal Information and Consent form only ONE of these forms needs to be filled out for you and any applicable family members who have an appointment.

Please note that anyone 18 years and older needs to fill out their own form.

For the Medical/Dental History form each person who has an appointment must fill out a form.

For the Financial Agreement only one form needs to be filled out for the family.

MONTEREY DENTAL CENTRE

NAME *Last* *First*	**DATE OF BIRTH** *(Day/Mos/Year)*	**GENDER** *MALE/ FEMALE/ OTHER*
NAME *Last* *First*	**DATE OF BIRTH** *(Day/Mos/Year)*	**GENDER** *MALE/ FEMALE/ OTHER*
NAME *Last* *First*	**DATE OF BIRTH** *(Day/Mos/Year)*	**GENDER** *MALE/ FEMALE/ OTHER*
NAME *Last* *First*	**DATE OF BIRTH** *(Day/Mos/Year)*	**GENDER** *MALE/ FEMALE/ OTHER*

ADDRESS	**CITY**	**POSTAL CODE**

Our office utilizes an automated system which sends out text and email reminders. When you get our reminders we ask that you please respond back to confirm your appointment(s).

CELL NUMBER #1 ***(Best number to contact you)*** ( )	*To whom does this cell number belong to?*
CELL NUMBER #2 ***(Alternative contact number)*** ( )	*To whom does this cell number belong to?*

EMAIL #1 ***(Best email to contact)***	
EMAIL #2 ***(Alternative email)***	

Home Phone Number ( )	**NAME AND PHONE NUMBER OF EMERGENCY CONTACT**

FOR MINORS WHO IS RESPONSIBLE FOR THE ACCOUNT?	

How did you hear about our office? (Please circle one)

Monterey Dental Website   Facebook   Newsletter   Patient   Location   Walk In

Chestermere LifepathWellness   Google Ads   Other: ______________________

Consent: To the best of my knowledge all of the preceding answers and information provided are complete and accurate. If I (or anyone listed on this form) ever have any changes (health, address, insurance, etc) I will inform the dental office at my next appointment. I grant permission to you and your assignees to contact me to discuss matters related to this form. I also authorize you and/or your parent company to send me emails relating to our services, events and promotions. I assume responsibility for all fees associated to my dental treatment.

Signature of patient, parent or guardian: ____   Date: ________________

Please remember to flip sheet over and fill out the Consent Form

Monterey Dental Centre
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 in this form, we also collect, use and disclose personal information when permitted or required by law.

Information is collected such as names; home and work addresses; home, work and cell phone numbers and e-mail addresses (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 materials
- To follow up with treatment and/or customer services

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.

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

Patients' Medical Information is disclosed for the following purposes:

- 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/specialists where we are seeking a second opinion or they have asked us to provide a second opinion and the patient has consented to this.
- To other dentists/specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment
- 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/our personal information as set out above.

Patient(s) Name(s) ____

____

____

____

Signature of patient/parent/guardian: ______________________________________

Date: ______________________________________

MONTEREY DENTAL CENTRE – MEDICAL HISTORY

Patient Name: ______________________________ Age: ______________

Name of Medical Doctor: ______________________

Please check all that apply to you:

__AIDS OR HIV
__ARTHRITIS
__BLOOD DISORDER/EXCESSIVE BLEEDING
__DIABETES
__GLAUCOMA
__HEPATITIS (TYPE ____)
__KIDNEY DISEASE
__MENTAL OR NERVOUS DISORDERS
__SINUS PROBLEMS
__ULCERS
__ALCOHOL OR DRUG ABUSE
__ARTIFICIAL VALVES/JOINTS/PINS
__CANCER/RADIATION TREATMENT
__DIZZINESS/FAINTING
__HEAD INJURIES
__HIGH BLOOD PRESSURE
__LIVER DISEASE
__PACEMAKER
__STD/VENEREAL DISEASE
__ANEMIA
__ASTHMA
__CONGESTIVE HEART FAILURE
__EPILEPSY
__HEART DISEASE
__HIGH CHOLESTROL
__LOW BLOOD PRESSURE
__RESPIRATORY PROBLEMS
__STROKE (WHEN __________)

Are you presently being treated for any other illness? YES NO

If yes please describe: ____

Are you aware of any change in your health in the last
24 hours (fever, chills, new cough or diarrhea)? YES NO

Are you required to take antibiotics for dental treatment
due to a heart condition or joint/pin surgery? YES NO

FEMALES: Are you pregnant? YES NO Due date: ____________________

Are you breastfeeding? YES NO

MALES: Prostate disorders YES NO Type: ______________________

SMOKERS: (Cigarettes, Cannabis or Chew)
How long have you been smoking/chewing for: ______________________

How many cigarettes/how much chew per day: ______________________

ALLERGIES to:

__ASPIRIN __CODEINE __ERYTHROMYCIN __HAY FEVER __LATEX __PENICILLIN

__SULPHA __LOCAL ANESTHETIC (FREEZING) __OTHER (PLEASE LIST) ____________________

LIST OF MEDICATIONS, SUPPLEMENTS, VITAMINS, HERBS YOU ARE PRESENTLY TAKING:

DRUG	PURPOSE	DRUG	PURPOSE

Please advise us in the future if there are any changes in your medical history or any medications you may be taking.

Please remember to fill out the other side for your dental history.

MONTEREY DENTAL CENTRE – DENTAL HISTORY

Date of most recent dental exam: _____ / _____ / _____
Day Mos Year

Date of most recent cleaning: _____ / ______ / ______

WHAT IS YOUR IMMEDIATE CONCERN? ____

Are you fearful of dental treatment?	YES	NO
Have you ever fainted or had complications following dental treatment?	YES	NO
Have you ever had any injury, surgery or x-ray therapy to the face or jaws?	YES	NO
Have you ever had trouble getting numb or had reactions to local anaesthetic?	YES	NO
Are any teeth sensitive to hot, cold, biting, sweets or are you avoiding brushing any parts of your mouth?	YES	NO
Do you have problems with your jaw joint (pain, sounds, limited opening, locking or popping)?	YES	NO
Do you wear or have you ever worn a bite appliance?	YES	NO
Did you ever have orthodontics or Invisalign?	YES	NO
Have you ever whitened (bleached) your teeth?	YES	NO
Is there anything about the appearance of your teeth/smile that you would like to change?	YES	NO

If you answered YES to the question above what would you like to change about your teeth/smile?

PLEASE SIGN IN THE PRESENCE OF THE DENTAL ASSISTANT OR HYGIENIST

Patient, parent or guardian signature: ________________________________ Date: ______________

Dentist/RDH/RDA signature: ____________________________________ Date: ______________

Please remember to fill out the other side for your medical history.

MONTEREY DENTAL CENTRE

Financial Agreement

We offer 2 different options in which your dental treatment can be paid. Please choose one of the following two options.

Option One _____ (This option is also for clients with NO insurance)
You may pay in full at the time of service, after which we will submit your dental claim on your behalf and have the insurance company issue the cheque directly back to you.

Option Two_____
Direct Billing – Assignment of Benefits from your insurance company will require a valid credit card number to be left on file. This includes dual insurance holders. Your deductible and estimated co-payment are due in full at the time of services rendered. Direct billing is a courtesy we offer to our patients.

All dental procedures in our practice are treatment planned based on the dental needs of the individual patient not limited to the benefits extended to the patient by their insurance provider.

PLEASE NOTE NO VISA OR MASTERCARD *DEBIT* CARDS

Credit Card Authorization

I authorize Monterey Dental Center to keep my signature on file and to charge my Visa/MasterCard account for:

- **Balance of charges not paid by my insurance will be charged to the credit card on file**

Patient Name: ____

Cardholder Name:____

Cardholder Address: ____

Phone Number: (Home) _____________ (Work) _____________ (Cell) _____________

Credit Card: **Visa** **MasterCard**

Card Number: _______ /_________/_________/_________ Exp Date:____________

Cardholder Signature:____

Insurance Authorization

I hereby authorize payment directly to Monterey Dental Center, for services rendered, otherwise payable to me. I authorize the releases of any information relating to my dental claims through this office.

Authorized Signature: ____________________________________ Date: ____________