OFFICE POLICIES
PLEASE READ THOROUGHLY

Insurance companies will only pay a portion of your treatment. While some claim to cover 100% of treatment costs, they often only cover 100% of the fee that they set for that treatment, not the fee that is set by the British Columbia Dental Association. This means that there is almost always a portion that will be charged to the patient. Payment for service is expected at the end of each appointment. As a courtesy to our patients, our staff may handle insurance forms but it is your responsibility to be aware of any limits to your insurance plan. As the insurance company is bound by Personal Health Information Act and will not share that information with the dental office. It is your responsibility to pay the balance that they do not cover. We may require a credit card on file to clear up balances that are not covered, if a charge will be over $50 we will contact you before charging.

Estimated fees given are only good for six months, and are subject to change.

CANCELATION OF APPOINTMENTS WITH LESS THAN 48 HOURS NOTICE MAY BE SUBJECT TO A $153.00 LATE CANCELLATION FEE.

If short notice cancellations are a reoccurring issue, we will require a deposit of $150 to reserve a time with any of our providers.

Deposits will be required for large procedures (any appointment over $500) on the day of the consult or initial appointment. We will still submit to your insurance for coverage and should they cover 100%, we will refund, or keep a credit on file. If you decide to not proceed with an appointment that includes a lab fee, the deposit will go towards covering the lab fee or any work that we did preparing for your appointment.

We do not do payment plans for patients at this time. Patients are able to put down money and build up a credit until they have enough on their file to go through with an appointment if they will be unable to pay in full at the time of completion.

All dental treatment requires a diagnostic exam. This exam will require x-rays. We reserve the right to refuse to provide treatment if you do not have the proper diagnostic tests. This includes dental cleanings. Guidelines from the CDHBC prevent our hygienists from treating you if you have not had an exam with the dentist in the last 365 days.

We do our best to maintain your privacy. Information collected on this form and throughout your treatment will be confidential; however, it may be used for the following:

Communication with you, your insurance company, and other health care providers; if required by our governing bodies (BCDA, CDA, CDSBC), the RCMP, or another party as permitted or required by law. Parents not listed on file requesting information for their children be required to provide proof of custody.

All medical treatments carry with them a certain amount of risk. These risks are greatly minimized when you make your dentist aware of existing concerns. Not informing your dentist of medications, allergies, existing or past medical conditions, or recreational drug use, may lead to severe conditions or death. Please do your best to make sure that your medical information is accurate and up to date.

One risk of dental treatment, although rare, is paresthesia. This is where a nerve that has been frozen or otherwise traumatized may temporarily or permanently lose feeling in the tongue and/or face.

I have read and understand the above information:

Signature of Patient or Guardian: **Date:**

_____ _____

SALMON ARM Dental

Dr. Russell Kearl Dr. Janine De Klerk

PATIENT INFORMATION

Legal Name: _____ Male: ____ Female : ____

Preferred Name: _____ Date of Birth (DD/MM/YYYY): _____

Home Phone: _____ Cell: _____ Work: _____ EXT:____

Physical Address/PO Box : _____ City: _____ Prov : ___ Postal Code : _____

Physical Address/PO Box : _____ City: _____ Prov : ___ Postal Code : _____

Email : _____ Occupation : _____

Emergency Contact : _____ Relation : _____ Phone : _____

How did you hear about our office? (Name if applicable) : _____

DENTAL HISTORY

Date of last dental visit / Reason : _____

Previous Dentist : _____

Have you had any x-rays in the last year (if YES – where?) : _____

Are you having any pain in your teeth? YES / NO Explain : _____

Are you concerned with the appearance of your teeth? YES /NO Explain : _____

Have past dental experiences been satisfactory? YES / NO Explain : _____

Do you have any of the following?

- ○ Sensitivity to hot / cold / sweets / biting
- ○ Bleeding gums
- ○ Broken teeth or fillings
- ○ Chronic bad breath
- ○ Suffering from dry mouth
- ○ Food catches between teeth
- ○ Grinding or clenching
- ○ Had an injury to teeth or jaw
- ○ Loose teeth
- ○ Cold sores
- ○ Treated for gum disease or told you have bone loss/gum loss around your teeth
- ○ Jaw pain
- ○ Sores / growths / swellings in mouth
- ○ Dental fear / Anxiety
- ○ Reaction to dental anesthetic

MEDICAL HISTORY

Do you or have you ever had any of the following:

- AIDS / HIV
- Arthritis
- Anxiety
- Asthma
- Autoimmune Disease
- Artificial Joint Replacement
- Artificial Heart Valve
- Back / Neck Pain
- Blood Disorder
- Breathing / Lung Problems
- Cancer
- Chemotherapy
- Radiation Treatment
- Congenital Heart Disorder
- Cardiac Stent
- Diabetes Type 1 or Type 2
- Depression
- Epilepsy / Seizures
- Excessive Bleeding
- Fainting / Dizziness
- Gastrointestinal Issues
- Glaucoma / Eye Disorder
- Head Injury
- Heart Disease Explain : _____
- Heart Murmur
- Hepatitis A / B / C (specify)
- High / Low Blood Pressure (specify)
- Headaches / Migraine
- Heart Attack – Date _____
- Hormone Deficiency
- Infective Endocarditis
- Kidney Disease
- Liver Disease
- Mental Disorders
- Osteoporosis
- Currently Pregnant – Due _____
- Pacemaker
- Rheumatic / Scarlet Fever
- Sinus Issues
- Stroke – Date _____
- Sleep Apnea / Snoring
- Tuberculosis
- Tumors / Growths
- Thyroid Disease
- Ulcers
- Venereal Disease
- Vertigo

1. Name of General Physician / Phone Number : _____
2. Medications : _____

   _____
3. Allergies : Latex / Codeine / Penicillin / Clindamycin / Sulfa Drugs / NSAIDS (Aspirin, Ibuprofen, Naproxen etc.) Other Allergies? _____
4. Have you ever been recommended to take Antibiotics prior to dental treatment or surgery? _____
5. Explain your tobacco use history _____
6. Do you drink alcohol? YES / NO , Frequency _____
7. Do you use recreational drugs? YES / NO **Some drug interactions and dental local anesthetic may be <u>LETHAL</u>**

   If yes, what kind and how recent _____
8. Is there any other general heal condition, disease, or illness not listed above? Please explain

   _____

   _____

This medical information is accurate to the best of my knowledge and I will inform the dental professional if there are any changes

- Signature of Patient/Guardian : _____ Date _____