



Please complete the following information:

Full Name _____
Address _____ (Postal Code) _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Birthday (MM/DD/YY) _____

Full Name of Spouse _____
Telephone (Home) _____ (Work) _____
Birthday (MM/DD/YY) _____

Other Family Members / Are they patients of Dr. Cloud's? Yes or No

Emergency Contact _____ Telephone _____

How did you hear about our office? _____

Personal Information:

Full Name of Insured _____
Birthday (MM/DD/YY) _____
Name of Insurance Company _____
ID / Certificate Number _____
Policy Number _____
Name of Employer _____

Secondary Insurance Information:

Full Name of Insured _____
Birthday (MM/DD/YY) _____
Name of Insurance Company _____
ID / Certificate Number _____
Policy Number _____
Name of Employer _____

Dental Insurance

Professional services are rendered to a person, not to an insurance company. We will forward your detailed insurance information to your insurance company however you are responsible for all fees charged. We cannot provide services based on the assumption that they will be paid for by the insurance company. Insurance is one method of payment it is not a method of treatment. Due to the privacy law it is now your responsibility to be aware of your insurance coverage.

Payment

For the payment we accept Visa, MasterCard, Interac, and cash. We no longer accept cheques.

Consent

I understand and agree to the above office policies. I also understand that dental treatment including the use of anesthetics agents embodies a certain risk. I understand that the responsibility for payment for services provided in this office for my dependants or myself is mine, due and payable at the time services are rendered. In the event of default I fully understand that all charges incurred for collection costs and reasonable legal costs, as maybe required, are my responsibility.

Signature _____ Date _____

Printed Name _____



Dental Office Personal Information

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible 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, with their consent, 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