ENJOY Dental New Patient Forms

Are you completing this form for another person? ______________________

Your Name *Relationship*

Personal Information

Today's Date: ______________ Gender: M □ F □

Name ____

Prefix *Last* *First* *Middle*

Address ____

Street/Mailing *Suite #* *City* *Province* *Postal Code*

Contact ____

Circle Preferred *Home #* *Work #* *Cell #* *Email Address*

____

Date of Birth *Age* *Occupation* *How did you hear of us?*

Emergency Contact/Family Information

Relationship to Policy Holder: Spouse □ Guardian □ Other: ______________

Name ____

Prefix *Last* *First* *Middle*

Contact ____

Home # *Work #* *Cell #* *Email Address*

Insurance Coverage

Relationship of Patient to Policy Holder:

Self □ Spouse □ Dependent □

Have Insurance □

No Insurance □

Patient Name ____

Last *First* *Date of Birth*

Policy Holder Name ____

Last *First* *Date of Birth*

Address ____

Street/Mailing *Suite #* *City* *Province* *Postal Code*

____

Carrier/Insurance Company *Policy Number* *Div/Sec or Subscriber ID Number*

____

Employer *Street/Mailing* *Suite #* *City* *Province* *Postal Code*

Secondary Insurance

Relationship of Patient to Policy Holder:

Self □ Spouse □ Dependent □

Policy Holder Name ____

Last *First* *Date of Birth*

Address ____

Street/Mailing *Suite #* *City* *Province* *Postal Code*

____

Carrier/Insurance Company *Policy Number* *Div/Sec or Subscriber ID Number*

____

Employer *Street/Mailing* *Suite #* *City* *Province* *Postal Code*

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Responsibility for Fees and Payments

I understand that payment needs to be made to ENJOY Dental each time a service is rendered. In the event of other payment arrangements, all outstanding fees are my direct responsibility. I understand these arrangements do not necessarily cover 100% of ENJOY Dental procedure fees, even if these arrangements claim 100% coverage, as they may not match the ENJOY Dental fee schedule.

Authorized Consent to Release Information

I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described, to the named dentist:

Name of Patient, Parent, or Guardian *Signature of Patient, Parent, or Guardian* *Date*

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Ng and associates and authorize payment directly to him/her. This authorization shall continue in effect until the undersigned revokes the same.

Name of Patient, Parent, or Guardian *Signature of Patient, Parent, or Guardian* *Date*

Consent for Examinations, Records, Maintenance, and Consent Withdrawal

I hereby grant Dr. Ng and associates permission to perform appropriate dental examinations and obtain appropriate imaging (commonly known as photographs and x-rays) as deemed necessary by the dental practitioner to diagnose my oral health condition in accordance with Canadian Dental Association guidelines so long as I am an active patient of Dr. Ng and associates.

I hereby grant Dr. Ng and associates and their dental auxiliaries permission to provide basic preventative care (including fluoride, polishing, and scaling) at appropriate intervals to maintain my oral health as deemed necessary by the dental practitioner.

I understand that not all treatments provided may require a separate written and signed consent form. I acknowledge that verbal consent is sufficient to acknowledge my understanding and consent for procedures consented to. No procedure will be started without consent.

I understand that I will not be considered an active patient of Dr. Ng and associates if I refuse to be seen or am not seen by Dr. Ng and associates for a period of 3 years or greater. After this time, should I choose to return, I understand I will be screened and treated as a new patient.

I understand that I may withdraw consent for dental treatment at any time verbally or in written form.

Name of Patient, Parent, or Guardian *Signature of Patient, Parent, or Guardian* *Date*

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Release of Records:

I authorize the release of all my records to the following dentists and dentists working at the following clinics:

Dentists:	Dr. Richard Ng	15277 Castledowns Rd. NW
	Dr. Enoch Ng	Edmonton, Alberta, T5X 3N5
	ENJOY Dental	780-457-2227

Your records (written, photos, models, digital, etc) are protected by privacy laws and will not be released unless authorized by you.

Demographic, medical, and other personal information collected may be used and shared with others for multiple purposes including, but not limited to, the following:

- To open and update patient files
- To send reminders to patients concerning the need for further dental examination or treatment
- To send patients informational material about our dental practice
- To use in a de-identified manner for research, teaching, and promotional purposes and to improve our practice

- Make arrangements for the payment of dental services
  - Invoice patients for dental services, to process credit card payments, and collect unpaid accounts
  - Process claims for payment or reimbursement from 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 where the patient has asked us to submit a claim on the patient's behalf

- To other health care providers where:
  - We are seeking a second opinion on the patients dental and medical condition
  - The patient is being referred by us to the other provider for treatment
  - The other provider is asking us for a second opinion

- 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 then take steps to ensure the prospective purchaser safeguards all personal information.

- The Alberta Dental Association and College, who may request to review records and interview our staff as part of its regulatory activities in the public interest.

I have read the information listed above and authorize the release of all my records to the above listed dentists:

Name of Patient, Parent, or Guardian *Signature of Patient, Parent, or Guardian* *Date*

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Dental Information

(Please Check All That Apply To You)

Gums bleed when you brush or floss	☐	Earaches, neck pain, or morning headaches	☐
Teeth sensitive to hot, cold, sweets, or chewing	☐	Clicking, popping, or discomfort in jaw joint	☐
Food or floss gets stuck between your teeth	☐	Sores or ulcers in mouth	☐
Currently experiencing dental pain/discomfort	☐	Serious injury to head/mouth	☐
Snore, mouth breathe, or grind teeth at night	☐	Problems with previous dental treatment	☐

Reason for Today's Visit *Date of Last Dental Exam* *Date of Last Dental X-Rays*

Medical Information

Have you had a serious illness, operation, or been hospitalized in the last 5 years? **Yes** ☐ **No** ☐

If yes, what was the illness or problem?

Family Doctor/Physician Name *Phone Number*

Date of Last Physical Exam:

Do you have any known allergies?

Please List:

Please list all medications, supplements, naturals and herbals you are taking:

Review of Systems

(Please Check All That Apply To You in the Present or the Past)

Antibiotic Prophylaxis Needed
- Joint Replacement/Artificial Joints ☐
- Artificial (Prosthetic) Heart Valve ☐
- Congenital Heart Disease (CHD) ☐
- Previously Recommended Antibiotics for Dental Treatment ☐
- Other (explain):

Breathing
- Asthma (Last Hospitalized:______) ☐
- Sinus Trouble ☐
- Tuberculosis ☐
- Been told you snore while asleep ☐
- Been told you need a CPAP ☐
- Other (explain):

Muscles, Bones, Immune System
- Osteoarthritis ☐
- Rheumatoid Arthritis ☐
- Osteoporosis ☐
- Hepatitis (A, B, C, D, or E) ☐
- STD/HIV/AIDS (Specify:_________) ☐
- Recurrent/Persistent Infection ☐
- Other (explain):

Brain and Sleep
- Difficulty Sleeping/Sleep Disorders ☐
- Headaches/Migraines ☐
- Difficulty Falling Asleep ☐
- Wake Up During the Night ☐
- Other (explain):

Heart and Blood
- Previous Heart Related Surgery ☐
- High Blood Pressure ☐
- Heart Disease ☐
- Other (explain):

Gut and Hormones
- Diabetes (Current HbA1c:______) ☐
- Kidney/Liver Problems ☐
- Heart Burn/Acid Reflux (GERD) ☐
- Eating Disorders: ☐
- Other (explain):

Female Only Are you Pregnant? ☐
If yes, what trimester?

Other

Cancer Treatment	☐	Chronic Pain	☐	Head/Neck Injury	☐
Other disease/condition?	☐	Cosmetic Surgery	☐	Eye Surgery in Last 6 Months	☐

Explain:

(For patients who have not checked any boxes)

I certify that I have no known medical conditions and am negative to all conditions listed above ☐

I certify that I am currently taking no medications, supplements, naturals or herbals ☐

Name of Patient, Parent, or Guardian *Signature of Patient, Parent, or Guardian* *Date*

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