

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

Employer

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

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.

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 (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 preventative and basic care (including fluoride, polishing, scaling, fillings, etc) 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 may withdraw consent for dental treatment at any time verbally or in written form.

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.

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 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 Dr. Ng and associates. 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.

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