IMAGE
Dental Care

PATIENT REGISTRATION FORM

Patient Information

First Name: _____ Last Name: _____ Today's Date: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ Gender: _____

Mailing Address: _____

Occupation: _____ Place of Business: _____

Responsible Party

Your Spouse/Parent/Guardian's Name: _____

His/Her Occupation: _____ His/Her Employer: _____

Name of family member responsible for payment of your account:_____

How did you hear about our office? _____

Emergency Contact Name:_____ Phone Number:_____

Treatment Interested In

☐ New Patient Exam and Hygiene ☐ Hygiene Only ☐ Emergency Exam ☐ Specific Exam

☐ Tooth Restoration / Extraction ☐ Invisalign ☐ Teeth Whitening

Insurance Information

Do you have Dental Insurance? ◯ Yes ◯ No Are you the main Policy Holder? ◯ Yes ◯ No

If no, please provide the name of the policy holder: _____

Group Policy Number: _____ Certificate or ID Number: _____

Policy Holder Date of Birth: _____Insuring Company:_____

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Payment Plan

Are you interested in a payment plan for dental services? ◯ Yes ◯ No

Medical Information

Please note: Prior to any dental treatment, our office requires a complete medical history. Knowing any health problems and/or medications you may be taking can avoid problems when treatment commences. Thank you for taking the time to answer these questions.

Family Doctor's Name: _____ Last Medical Exam:_____

What pharmacy do you use? _____

Have you ever had a serious injury or major operation? ◯ Yes ◯ No

Are you in good health now? ◯ Yes ◯ No

Are you presently being treated by a physicians? ◯ Yes ◯ No

Are you taking any medications, pills, drugs, or medicine? ◯ Yes ◯ No

Allergies: Have you ever had a reaction to any of the following:

☐ Penicillin ☐ Codeine ☐ General Anesthetic ☐ Aspirin

☐ Local Anesthetic (Freezing) ☐ Other ☐ None

Do you have or have you had any of the following conditions? Please check all that apply:

☐ Anemia ☐ Angina Pectoris ☐ Artificial Heart Valve

☐ Artificial Joint ☐ Arthritis ☐ Asthma

☐ Bruise Easily ☐ Bleeding problem or blood disorder ☐ Cancer of any kind

☐ Chemotherapy ☐ Chest pains ☐ Chronic Bronchitis

☐ Congenital Heart Lesions ☐ Cortisone Therapy ☐ Diabetes

☐ Drug/Alcohol Abuse ☐ Emphysema ☐ Epilepsy or seizures

☐ Fainting/Dizzy Spells ☐ Gastrointestinal ds ☐ Glaucoma

☐ Growth/Tumor ☐ Heart Attack/Disease ☐ Heart Murmur

☐ Heart Pacemaker ☐ Heart Surgery ☐ Hemophilia

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☐ Hepatitis A (infectious) ☐ Hepatitis B (serum) ☐ High or low blood pressure

☐ HIV+AIDS ☐ Kidney Disease ☐ Jaundice

☐ Liver Disease ☐ Mental/Nervous ds ☐ Mitral Valve Prolapse

☐ Radiation Therapy ☐ Rheumatic Fever ☐ Stroke

☐ Thyroid Disease ☐ Tuberculosis ☐ Stomach Disorders/Ulcers

☐ Frequent Headaches ☐ Infectious Disease ☐ You suffer from diarrhea

☐ You currently suffer from a prolonged cough ☐ You currently have an undiagnosed skin rash

☐ None of the above

Do you get chest pains upon exertion or shortness of breath after mild exercise?	○ Yes	○ No
Do you get swelling of your ankles or have difficulty lying flat on your back?	○ Yes	○ No
Do you use controlled substances (cocaine, barbiturates, other)?	○ Yes	○ No
Have you ever had any excessive bleeding requiring treatment?	○ Yes	○ No
Do you smoke?	○ Yes	○ No
Are you pregnant?	○ Yes	○ No
Is there anything else we should know about your health?	○ Yes	○ No
Is there a dental problem you would like treated immediately?	○ Yes	○ No
Are there any other dental condition that concern you at present?	○ Yes	○ No
Are there any dental issues that you want addressed in the future?	○ Yes	○ No

How frequently do you see your dentist? _____

Date of your last dental visit? _____

Date of your last dental cleaning? _____

Date of your last x-rays? _____

Do you have any other family members that do not have a regular dentist? _____

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Do you have or have you had any of the following conditions?
Please check all that apply: (Choose as many as you like)

☐ Periodontal Treatment (treatment of the gums)
☐ Dentures or partial dentures
☐ Orthodontics Treatment (to straighten or realign teeth)
☐ Wisdom teeth removed
☐ A Bite Plate, Night Guard or Other Appliance
☐ Root canal treatment
☐ Crown or bridge
☐ None of the above

Do your gums bleed when brushing or eating, or do you suffer from pain or swelling of your gums?
◯ Yes ◯ No

Have you been given oral hygiene instruction in brushing, flossing or other instructions?
◯ Yes ◯ No

Have you ever had any injury, surgery, or x-ray therapy to the face or jaw? ◯ Yes ◯ No

Are there any growths or sore spots in your mouth? ◯ Yes ◯ No

Have you noticed any loose teeth, or, have any of your teeth shifted? ◯ Yes ◯ No

Does food catch between your teeth? ◯ Yes ◯ No

Are any of your teeth sensitive to heat, cold, sweets or pressure? ◯ Yes ◯ No

Have you ever experienced any of the following jaw problems?
Please check all that apply: (Choose as many as you like)

☐ Popping/clicking in your jaw joints
☐ Pain in your jaw joints, around your ear or side of your face
☐ Difficulty opening or closing
☐ Pain when teeth are clenched
☐ Pain or difficulty while chewing
☐ None of the above

Do you have any of the following habits? Please check all that apply: (Choose as many as you like)

☐ Biting your cheeks or lips
☐ Mouth breathing while awake or asleep
☐ Gag reflex
☐ Clenching or grinding your teeth while awake or asleep?
☐ None of the above

Are you missing any teeth? ◯ Yes ◯ No

Are you dissatisfied with the appearance of your teeth? ◯ Yes ◯ No

What would you like to see improved if anything? _____

Are you interested in discussing any of the following with the dentist or hygienist?

☐ Teeth whitening or bleaching ☐ Cosmetic dentistry ☐ Orthodontic treatment

Have you ever had local anesthetics (freezing)? ◯ Yes ◯ No

Have you had dental x-rays taken in the last 5 years? ◯ Yes ◯ No

Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? ◯ Yes ◯ No

CONSENT

Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information. Collecting, using and disclosing all personal information will be done in a responsible and professional manner and in accordance with The Personal Information Protection and Electronic Documents Act and Health Information Act.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, cell phone numbers, and e-mail addresses. (Collectively referred to as "Contact information") Contact Information is collected, shared with all family members 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.
- To confirm appointments

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 arrangement 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 bas asked up 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 to us to the other dentist or dental specialist for treatment.
- To other dentist 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 to us to the other health care professional for either a second opinion or treatment.

The Health Information Act is designed to facilitate the sharing of health information, in a controlled way, within a "circle of care". Those that are in the circle of care include; dentists, dental specialists, personal physicians, nursing homes, Alberta Health and Wellness and Alberta Health Services. Disclosure outside of this circle of care is strictly controlled. You may at any time designate any restriction as to whom we may disclose your personal information or restrict the content of disclosure.

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.

This is to certify that I, undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, and I will assume responsibility for fees associated with those procedures.

In addition, I consent to the collection, use and disclosure of my personal information as set out above.

I also agree that any images/video taken of me, excluding dental records and x-rays, may be used in whole or in part for promotional purposes online or in print. In compliance with Canadian Anti-Spam Laws, you understand that by signing this form, you give us permission to send you information such as appointment reminders, appointment confirmations, news and events.

Information retention and destruction

We will retain your personal information for the period necessary to continue providing oral health services to you, and for its related administration. We will destroy information in a secure manner when the information is no longer necessary for the provision of oral health services and is not required to be retained for compliance with provincial or federal regulations or statues.

Contact

Should you have any questions, comments or concerns, please bring them to the attention of our privacy officer. We will be pleased to assist you.

Consent Acknowledgment

Having read and understood the Privacy Information Consent Form, I consent to the collection, use and disclosure of my personal information as presented in the Statement.

Financial Policy and Agreement

Thank you for choosing us for your dental needs. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial abilities. To confirm your understanding with our policies, please read the following.

Dental Treatment

Dental treatment fees given are based on the treatments anticipated at the initial comprehensive examination. Some teeth may have hidden decay, fractures, affected nerves or other unanticipated conditions requiring more extensive dental treatments. In situations where additional charges are involved we will explain the reason for additional treatment and their respective fees prior to the services being rendered.

Dental Insurance

We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family; regardless of any insurance coverage. Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the insurance carrier and the dentist. As a convenience to you, our office will submit charges to your insurance carrier. We urge you to be fully aware of the provisions of your policy since insurance coverage varies dramatically.

Payment Plans

As a benefit to our patients, our office offers no interest payment plans. Payment plans are not available on initial visits. Our payment plan structure is 35% of balance due on the date of service and the remaining balance split over three months/or the remainder of treatment. A valid credit card is needed on file before treatment in order to proceed with a payment plan. A $50.00 NSF charge+ 8.5% interest will be applied to your account if we are unable to process the payment.

Financial Consent

I am aware that any unpaid balances over 90 days without any financial arrangements in place are sent to a third party collection agency.

I give permission for claims and pre-authorizations to be sent manually and/or electronically to my insurance.

I understand and agree, regardless of my insurance status, I am ultimately responsible for any unpaid balance on my account.

Short Notice Cancellation and No Show Policy

Changes to existing dental appointments are accepted within 2 days' notice for Monday to Friday appointments and 3 days' notice for Saturday and Sunday appointments. When less notice is given, this may result in a deposit being required to pre-book any future appointments. Thank you for your understanding of our policy. This question is required. *

Patient Consent Form for Incoming & Outgoing Phone calls and AI-Assisted Treatment Coordination & Conversation Recording

At Image Dental Care Deer Park, we are committed to delivering exceptional care by leveraging advanced technology, including AI-powered tools, to enhance accuracy in treatment planning and coordination.

Our office records all incoming and outgoing calls to ensure communication accuracy and quality of care.

To ensure precise documentation of your dentist's treatment intent and diagnosis, we use secure AI transcription software (Notta AI) to record and transcribe discussions between you and your dental provider. This helps our team accurately implement your treatment plan and improve communication.

Key Details:

- Confidentiality: Recordings are encrypted and stored securely in compliance with HIPAA and privacy laws.
- Purpose: Used solely for **clinical documentation, treatment coordination, and quality assurance.
- Voluntary Participation: Your consent is optional and will not affect the quality of care provided.
- Withdrawal: You may revoke consent at any time by notifying our office in writing.

By signing below, I give my consent to the recording, transcription, and AI-assisted analysis of my conversations with the dental team for clinical and administrative purposes.

Date: _____ **Patient Name:** _____

Signature of Patient or Guardian: _____