DROSU DENTAL

General & Cosmetic Dentistry

PERSONAL INFORMATION (please print)

(Last Name) (First Name)

(Address) (City) (Postal code)

D.O.B.: _____ / _____ / _____
Month Day Year

Home #: ( ) _____
Work #: ( ) _____
Cell #: ( ) _____

E-mail address: _____

In case of emergency, please contact: _____ Phone #: ( ) _____

Physician: _____ Phone #: ( ) _____

How well do you feel in the last 24 hrs? (any cough/fever/chills/shortness of breath/diarrhea/ rash)

_____

Any recent exposures to communicable infectious disease? (measles/chicken pox/tuberculosis) _____

Have you traveled to a foreign country within 30 days? If so, where? _____

Are you experiencing any strange symptoms since your return? _____

On a scale of 1 to 10 how do you rate your smile? 1 2 3 4 5 6 7 8 9 10

How did you hear about us?_____

MEDICAL HISTORY

1. Have you ever had a serious illness requiring hospitalization or extensive medical care? _____
2. Are you presently under the care of a physician? _____
3. Do you take medications now? _____
   If yes, please specify: _____
4. Have you ever had any of the following diseases? (Please check if applies)

___ Heart Murmur	___ Thyroid Disease	___ AIDS	___ Heart Attack
___ Other Heart Conditions	___ HBP/LBP	___ Hepatitis	___ Kidney Disease
___ Rheumatic Fever	___ Diabetes	___ Jaundice	___ Sinus Trouble
___ Joint Replacements	___ Hyper-Glycemia	___ Hypo-Glycemia	___Arthritis/Rheumatism
___ Cold sores	___ Liver Disease	___ Venereal Disease	___ Cancer
___ Tuberculosis	___ Epilepsy/Seizures	___ Stroke	___Drug Addiction
___ Lung Disease	___ Stomach/Intestinal	___ Mental/Nervous Disorder	
___Antimicrobid Therapy	___Prion disease	___Dementia	_____Other

5. Have you had any known contact with the AIDS virus? _____
6. Do you have any allergies? (asthma, hay fever, hives, rashes?) _____
7. Are you allergic to any medications or drugs? _____
   If yes, please circle or indicate: _____
   (aspirin, penicillin, Iodine, Sulfa, sleeping pills, local anesthesia, codeine or any other drugs)
8. Do you bruise easily or bleed abnormally? _____
9. Do you have any blood disorders such as anemia or taking blood thinners? _____
10. Have you ever had any injury, surgery or x-ray therapy to the face or jaws? _____
11. Do you have a tendency to faint? _____
12. Do you suffer from severe headaches? _____
13. Have you had any transplants? If yes, please indicate: _____
14. WOMEN ONLY: Are you Pregnant? _____
    If yes, which month: _____
15. WOMEN ONLY: Are you taking birth control pills? _____
16. Do you have any other medical conditions not listed you would like to notify us of? _____
    If yes, please explain: _____

DENTAL HISTORY

17. Date of last dental visit: _____ Dentist: _____
18. Do you have any oral habits such as clenching, grinding or nail biting? _____
19. Does your jaw crack or pop when opened widely? _____

(Continued on next page)

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20. Do your gums bleed when: Brushing _____ Flossing _____ Never _____
21. Do you have any present concerns regarding your smile, teeth or gums?

_____

PATIENT CERTIFICATION AND CONSENT

I, THE UNDERSIGNED, CERTIFY THAT THE ENTIRE ABOVE MEDICAL AND DENTAL INFORMATION IS TRUE TO MY KNOWLEDGE AND I HAVE NOT OMITTED ANY PERTINENT INFORMATION. I CONSENT TO THE PERFORMING OF DENTAL AND ORAL SURGERY PROCEDURES AS AGREED TO BE NECESSARY OR ADVISED AND I WILL ASSUME RESPONSIBILITY FOR THE FEES ASSOCIATED WITH THESE PROCEDURES, REGARDLESS OF DENTAL INSURANCE.

_____ _____

Patient/Parent/Guardian Signature **Date**

Personal Information Consent Form (Privacy Act)

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional 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 email 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.

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"). Patient's Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.
Patient's 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*

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DENTAL INSURANCE:

Excellent dental care is available with or without dental benefits; however, if you have dental benefits, as a courtesy to our patients, we will file your charges to your insurance carrier on your behalf if a valid credit card is left on your personal file. Any differences not covered from your benefits will be required to be paid on the date of service or charged to your credit card. Since the Privacy Act has been passed, some insurance companies will only release information/payments to the insured member and not to the dental office, therefore; any claims not paid from your insurance carrier after 30 days from date of service will be charged to your credit card.
It is the insured person's responsibility to understand their benefits as our staff are unable to keep track of all the individual details of each plan. Every plan is different, and the contract is still between yourself, your employer and your insurance carrier. Our team members will gladly assist you in completing the necessary forms to maximize your dental benefits and discuss your financial options.

I hereby assign my benefits payable, from claims submitted electronically or otherwise, to Dr. Alina Drosu and authorize payment directly to her.

(Signature) _____

_____ VISA _____ M/C

CARD# _____

EXP DATE _____(MM/YR)

SIGNATURE OF CARDHOLDER: _____

CANCELLATION POLICY:

We respect our patient's time. For this reason, we would like to advise you that your appointments are reserved to meet both you and your family's needs. The length of your appointment is based on your individual treatment. Please respect the time we have reserved for you. If you find that the appointment time that we have scheduled requires change, ***please note that we ask that you provide us with 2 Business days' notice***. *If less than 48 hours notice is given, a cancellation fee of $50.00 - $100.00 will apply.*

I have read, understand and accept the terms of the above outlined policies for insurance and financial commitments that may occur.

Name (please print)_____

Signature_____ Date_____

We thank you for your cooperation, and look forward to providing
exceptional care for you and your family.

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