SUMMIT DENTAL

PATIENT PERSONAL INFORMATION

Legal First Name:_____Preferred_____Last_____

Date of Birth (d/m/y) _____

Address _____

City _____Prov._____Postal Code_____

Telephone Home (_____)_____ Work (_____)_____ Cell (_____)_____

Email: _____

If Under 18 parents/guardians names_____

Student – Name of Post Secondary Institution_____

Employer_____ Occupation _____

Marital Status _____ Name of Spouse _____Date of Birth(d/m/y)_____

Personal Physician _____Tel_____

Previous Dentist _____Tel_____

How did you hear about our office? (internet ,sign on building, newsletter, current patient, other)_____

In case of emergency notify: Name_____Relationship_____

Tel _____or _____

Dental Benefit Information:

1st Policy	2nd Policy
Policy Holder _____	Policy Holder _____
Insurance Co. _____	Insurance Co. _____
Date of birth (d/m/y)_____	Date of birth (d/m/y)_____
Employer _____	Employer _____
Policy/Group # _____	Policy/Group # _____
ID/Certificate # _____	ID/Certificate # _____
Patient relationship to insured: Self/Spouse/Child	Patient relationship to insured: Self/Spouse/Child

SUMMIT DENTAL

Dental Office Personal Information Consent Form

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 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 (such as credit card numbers and expiry dates) may be collected in order to make arrangements for the payment of dental services. It is not shared with third parties without your consent, unless permitted by law for outstanding bill collection purposes.

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' Dental 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 third party health benefit providers and insurance companies where the patient has asked us to submit a claim on the patient's behalf for predetermination of dental benefits
- 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
- to the patient's legal counsel on request as support documents for injury litigation
- to dental laboratories where we are having dental items fabricated for the completion of dental services
- 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*** ***(Parent or Guardian if under 18)***

Disclaimer – This document represents the Privacy Policy for; Summit Dental Joint Venture, Dr. John Hubbard, John A. Hubbard Professional Corporation, Dr Kelly Chotowetz, Kelly Chotowetz Professional Corporation.

SUMMIT DENTAL

PATIENT CONSENT / INSURANCE RELEASE

Patient Name _____

Treatment Consent
This is to certify that I the undersigned, give consent to the dentists and dental staff of Summit Dental to carry out oral examinations, dental procedures, dental treatments dental operations, dental radiographs or other records as may be recommended.

Fees and Treatment
Fees will be assessed for diagnosis, treatment, consultations and other services. I am encouraged to ask questions regarding procedures or treatments and the resulting fees.

I further accept the financial policies of the office and that dental fees in the office are based on the complexity of the dental procedure. I am responsible for payment of services rendered in this office, regardless of any third party dental coverage, which I may have.

Appointment Scheduling
I understand that once an appointment is made the time is reserved for me, therefore I shall notify Summit Dental two business days in advance of any cancellation or a cancellation fee may apply.

Insurance / Dental Benefits
I understand as a *service* to patients, direct billing to dental benefit providers (insurance companies) is accepted. Due to the *many differences* in individual benefit plans it is difficult to estimate *exact* amounts covered by plans. Therefore patient portions are *estimates only*.

I understand that it may become necessary to release my Personal Information to third party health benefit providers and insurance companies where a claim has been submitted on my behalf for reimbursement or payment of all or part of the cost of dental treatment or for the predetermination of dental benefits.

I understand under Canadian Privacy Legislation the dental office may no longer be able to obtain information on my policy and coverage directly from my benefit provider. I will assist the office in obtaining any information necessary and forward it promptly to the dental office.

Patients will be *responsible* for all balances

I acknowledge that I have read this consent and that I understand the contents of this consent form.

_____
Signature of patient, parent or guardian

_____
Date

AUTHORIZATION FOR ELECTRONIC DENTAL CLAIM SUBMISSION VIA CDAnet

I authorize release, to my benefit provider, the information contained in electronically submitted dental claims and preauthorizations for myself and those covered by my benefit policy.

_____ _____

Signature **Date**

I hereby assign my benefits payable from claims submitted electronically and authorize direct payment (where permitted by my benefit provider) to Summit Dental/John Hubbard Professional Corporation, Kelly Chotowetz Professional Corporation or Dr. Carla Nicholson.
(see below for conditions)

_____ _____

Signature **Date**

I understand that the fees forwarded to my benefit provider may not be covered by or may exceed my plan limitations. I understand that I am financially responsible to my dentist for the entire cost of all treatment.

_____ _____

Signature **Date**

ELECTRONIC COMMUNICATION

Summit Dental, John A. Hubbard Professional Corporation,
Kelly Chotowetz Professional Corporation

To ensure we are able to contact you with information about your dental health including reminders of recommended dental treatment, information on your oral health and confirmation of upcoming dental appointments we will from time to time send you electronic messages via email, text message or voice message.

Under Government of Canada Regulations without your consent we will not be able to communicate this important information to you electronically. Please confirm your consent to receive electronic communications from Summit Dental.

Name _____ **Date**_____

☐ I consent

☐ I do not consent

At any time you can revoke your consent by emailing summitdental@summitdental.ca

Patient's Payment / Insurance Responsibilities

Name _____

Phone (Hm)_____**(Bus)**_____
(Cell)_____

Date _____

Visa / MasterCard / AmEx _____

Expiry date mth _____ yr _____

CVC _____ (last 3 numbers on the back of the card)

- Patients will be permitted to assign benefits to the dental office ***only*** **if a credit card is left on file** to be charged with the remaining balance once a payment from the benefit provider is received. (Some exceptions apply dependent on benefit provider involved)

- If payment is being sent by the benefit provider directly to the patient post-dated payments may be permitted to be placed on file dated two weeks from the date of service. The *estimated* "Out of Pocket" portion of your benefit coverage is to be paid at the time of each appointment. (exceptions may be made for large treatment plans).

I hereby permit Summit Dental Joint Venture to debit my credit card as described above.

X_____
Signature of card holder