Horizon Dental

#1-760 Mayfair St,
Kamloops, BC V2B 0E5
tel: 778-765-3928
fax: 778-765-3973

NEW PATIENT QUESTIONNAIRE

CONTACT INFORMATION

Date: _____ Preferred Pronoun: He/Him She/Her They/Them Other:_____

First Name: _____ Middle Name: _____ Last Name:_____

Date of Birth: Y_____/M_____/D _____ Age: _____ BC Care Card #: _____

Email address: _____ Home Address: _____

City: _____ Postal Code: _____

Phone, Res: _____ Cellular: _____

Person to notify in case of emergency: _____ Phone: _____

Primary Doctor Name: _____ Phone: _____

Name of Previous Dentist:_____ Date of Last Dental Visit: Y_____/M_____

How did you find us?_____

The cost of a standard new patient exam, including necessary X-rays and photos for adults, is typically between $350 and $450. Any portion not covered by dental benefits will be due at the time of your appointment.

Please initial: _____

DENTAL HISTORY

	YeS	NO
1) Do you feel any pain to your teeth or mouth?	◯	◯
2) Do you have trouble "freezing"?	◯	◯
3) Have you had any cavities in the past 3 years?	◯	◯
4) Does your mouth feel dry or do you have difficulty swallowing?	◯	◯
5) Have your teeth changed in the last 5 years, become shorter, worn, or shifted place?	◯	◯
6) Do you bite your nails, chew ice, chew pens or have any other oral habits?	◯	◯
7) Have you ever worn a bite appliance?	◯	◯
8) Do you have dentures?	◯	◯
9) Have you ever had a head, neck or jaw injury?	◯	◯
10) Are you interested in sedation for dental treatment?	◯	◯

11) Have you had any of the following dental treatment:	◯ Orthodontics (braces)	◯ Periodontics (gums)	◯ Wisdom teeth removal	◯ Implants

12) Please tell us how you take care of your teeth:_____

13) Do you have any concerns about dental treatment – are you nervous about the dentist? Please explain: _____

_____

14) Is there anything about the appearance of your teeth you would like to change? Please explain:

15) Have you ever been disappointed with the appearance of previous dental work? Please explain:

_____

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MEDICAL HISTORY

Do you have or have you ever had:

◯ AIDS/HIV Positive	◯ Alzheimer's or Dementia	◯ Anemia	◯ Asthma
◯ Arthritis/Gout	◯ Artificial Joint(s)	◯ Artificial Heart Valve	◯ Autism or Special Needs
◯ Cancer	◯ Chemo or Radiation to the Head/Neck	◯ Diabetes type 1 or 2	◯ Emphysema, COPD, bronchitis, other lung disease
◯ Epilepsy/Seizures	◯ Fainting	◯ Glaucoma	◯ Hemophilia or blood disorder
◯ Hepatitis A B or C	◯ Heart disease or Trouble	◯ Heart surgery, stents	◯ High blood pressure
◯ Low Blood Pressure	◯ Heart Attack/ Failure	◯ Pace Maker	◯ Kidney problems
◯ Hearing difficulty or wear a hearing aid	◯ Lupus	◯ Mental/Nervous disorder	◯ Migraines or frequent headaches
◯ Organ Transplant	◯ Osteoporosis	◯ Snoring or Sleep Apnea	◯ Stomach or digestive issues (ie: reflux, ulcers, celiac disease)
◯ Stroke	◯ Thyroid Disease	◯ Is there anything else?_____	

Please list any prescription medications or supplements you are taking: _____

Please list any allergies, including to medications, latex, food, etc: _____

Have you had a bad reaction to any medications? Please explain: _____

	YES	NO
Have you ever used any form of Tobacco, Vaping, or are wearing a nicotine patch?	◯	◯
Have you been advised to take antibiotics before seeing a dentist?	◯	◯
Are you dependent on alcohol or drugs? Have you been treated for addiction?	◯	◯
Have you recently (in last 2 years) been hospitalized or had a major operation? Please explain:_____	◯	◯

FOR WOMEN - Are you: ◯ Pregnant or trying to become pregnant? ◯ Taking birth control?

NOTE: IT IS IMPORTANT THAT ANY CHANGES IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary to obtain information that is required for my dental care.

Signature: _____

Name: Parent or Legally Authorized Representative: _____

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Thank you for choosing our office. Our primary goal is to provide thorough dental care in a comfortable, relaxed environment. To ensure a long lasting and well-informed relationship we have listed our policies concerning you, the patient. Please read through the following policy information – should you have any questions please do not hesitate to ask one of our team members.

FINANCIAL POLICY

Insurance

We accept *most* types of dental insurance on assignment (meaning having the payment come directly to our office). Please check with our staff to ensure your insurance can be accepted before your initial visit.

We are happy to provide you (policy holder or patient) with assistance by submitting your claim electronically and filling out insurance forms.

Assignment is accepted provided that:

- The appropriate forms, cards and/or any other relevant insurance information are provided in a timely manner.
- The policyholder/subscriber is present to sign the appropriate forms for insurance processing.
- The policyholder/subscriber understands and agrees to pay for any outstanding amounts not covered by the insurance company in full at the time of treatment.
- The patient understands that if any difficulty is encountered by our office with the collection of payment from the insurance company, the patient is ultimately responsible for any outstanding payment and must deal with any insurance company inquiries.
- Assignment will not be accepted if correct, up-to-date insurance information is not provided.

Before each appointment, it is your responsibility to confirm your dental insurance coverage and understand its limits and short-comings to avoid unexpected charges. It is not our responsibility to know your dental insurance contract.

Payments

Prior to your visit, our team will make every attempt to provide you with an estimate of the costs, however this is not a guarantee and costs can go up or down depending on your individual needs. Upon completion of every dental visit, the front desk staff will produce an invoice outlining final costs. Please be prepared to pay any outstanding amount that is not covered by your insurance.

If signing on behalf of a minor, you are responsible to pay for their dental treatment.

Forms of payment

Cash, Debit, VISA, Master Card, E-Transfer, Cheque

Extensive or Long-Term Treatment

Treatment such as: crowns, bridges, implant crowns, or rehabilitation may require a separate payment agreement. This will be discussed at the time your customized treatment options are presented.

Please note: You are responsible for having your account paid in full each time treatment is provided. If payment is not received, an alternative arrangement can be discussed with our practice coordinator.

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Warranties

If you have an issue or concern regarding treatment, please alert the practice in a timely manner.

The Practice has chosen to provide a 5 year "warranty" on major treatment, which depreciates by 20% of cost each year after treatment is performed. Basic dental treatment falls under a 1-2 year warranty at the sole discretion of the dentist.

All "warranties" on dental treatment are void if the patient does not follow the recommended recare schedule, perform the recommended at-home dental hygiene and diet management, is not in good financial standing with the practice, or due to loss or accident/injury not related to the office.

SCHEDULING POLICY

Cancelling, Missed, & Late Appointments

If you are unable to attend your appointment, we ask that you inform us at least two working days (48 hours) prior to that appointment. This gives us an opportunity to give your appointment time to someone on our urgent care waiting list.

If you miss your appointment or cancel on short notice (less than 48 hours), we reserve the right to charge a fee based on the standard BC Dental Fee Guide, the amount of time booked, and what procedure was planned.

If you should arrive late, we may not be able to see you for that appointment or may have to limit the amount of treatment done.

The office reserves the right to dismiss a patient who repeatedly no-shows, cancels on short notice, or arrives late.

Cell Phones & Media Devices

Please feel free to use your cell phones and other media devices in our waiting area.

To ensure the privacy, comfort, and safety of all our patients and staff, **please respect the following rules**:

- Use earphones if you are watching a video or listening to music.
- Mute or turn off your device once you enter the operatory for your treatment.
- Respect the privacy of other patients and staff, and our need to provide you with a safe treatment environment.
- Refrain from moving, touching, or photographing equipment; or photographing or recording your procedure.

Unattended Minors

- Please note that we do not offer childcare services in our clinic.
- To ensure the comfort and safety of your child and our staff, we ask that all children aged 12 and under be supervised or accompanied by an adult at all times, while in the clinic.

Horizon Dental has a **zero-tolerance policy** for violence, threats of violence, harassment, or intimidation of any team member or client. The office reserves the right to immediately dismiss any patient who does not respect the safety and well-being of others, whether in person or through other means of communication.

Name:_____ Date:

Signature:_____

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PATIENT PERSONAL INFORMATION CONSENT FORM

We are committed to protecting the privacy of our patients' personal information in a responsible and professional manner. This document summarizes the personal information that we collect, use, and disclose in accordance with provisions set out in the Privacy Information Protect Act. 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 and work addresses; home, cell and 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 of 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 may be collected in order to make arrangements for the payment of dental services.

For the safety and security of our staff and patients, we collect audio and visual surveillance limited exclusively to the front lobby, hallways within the clinic, and outer entrances/exits to our office to minimize potential privacy intrusions. Access to recordings is restricted, stored securely, and destroyed within 30 days unless it may be required as part of a criminal, safety, or BCCHOP investigation for evidentiary 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' Medical Information is disclosed to the following:

- 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 patients' 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 where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professional 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.

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We may also use your photos and x-rays for educational or research purposes only. We will not distribute photos or x-rays without your permission; complete confidentiality will be respected.

If we are ever considering selling all or part of our practice, qualified potential purchasers may be granted access to patient information as part of the due diligence process. This is to verify information pertaining 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 BCCHOP 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/my child's personal information as set out above.

Name:_____ Date:_____

Signature:_____

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Insurance companies no longer share information about your plan with us, preferring to deal directly with patients, making it more difficult for us to find out the specific benefits or limits of your plan and providing accurate estimates for your dental treatment.

We will continue to submit your dental claims to your insurance claim on your behalf and use every effort to collect any money owing by your insurance company for treatment completed. Our office will contact you by phone and/or email to notify you of the amount owing on your account before payment is processed.

Financial information (such as credit card numbers and expiry dates) are collected in order to make financial arrangements for the payment of dental services. This information is not shared with any third parties, unless permitted by law for outstanding bill collection purposes.

Payment Contract

I authorize Dr. Cindy E Nagel Inc., at Horizon Dental, to process payment on my credit card for any outstanding amount owing on my account (for myself and/or any family members).

_____ Visa _____ MasterCard

Credit Card Number: _____-_____-_____-_____

Expiration Date: _____/_____ CVV: _____

Name as it appears on Card: _____

Authorized Signature: _____

For the Account of: _____