aldente DENTISTRY

Patient Registration Form

FOR OFFICE USE ONLY:
Type of Photo ID checked:

Staff name & signature:

Name: (Circle prefix) Mr. Mrs. Ms. Miss. Dr.	Preferred Name:	Date:
		Date of Birth:

Address:

If patient is a child or under the care of a Legal Guardian or Power of Attorney, please complete the following for the parent/Legal Guardian/Power of Attorney.

Name and relationship to patient:

Address (if different than that of patient):

FOR OFFICE USE ONLY:
Type of Photo ID checked:

Staff name & signature:

Home Phone #: Cell Phone #: Work Phone #:

E-mail Address:

Circle how you would prefer we contact you: Home Phone Cell Phone Work Phone Text Message E-mail

If you prefer us to contact you by phone, is there a preferred time of day?

Emergency contact name, telephone number, and their relationship to you:

Name of Family Doctor: City: Phone #:

Occupation:

Name and address of employer:

Do you have dental benefits? YES NO Do you also have SECONDARY dental benefits (eg. from spouse) YES NO

Primary Dental Benefits			Secondary Dental Benefits		
Name of Insured/Subscriber:		Date of Birth:	Name of Insured/Subscriber:		Date of Birth:
Insurance Carrier:		Tel:	Insurance Carrier:		Tel:
Group/Policy #	Cert.#	Division/Sect #	Group/Policy #	Cert.#	Division/Sect #

How did you hear about our office?

Privacy Act Notification:

I have been informed of the privacy policy of this office and understand that all information I have supplied will be used and disclosed as set out within this office policy.

Office Policy on Fees:

Payment is expected as soon as services are rendered, and in some instances, prepayments or deposits are required. You will be advised of cost estimates and any need for deposits or prepayments prior to treatment. Payment can be made in the form of cash, debit, VISA, Mastercard, American Express. Outstanding balances are subject to interest, late payment fees, and collection costs. We will help you submit your claims to your insurance company, and if there is a benefit due to you, your insurance company will pay that benefit directly to you.

Predeterminations:

Predeterminations are estimates we send to your insurance carrier for suggested treatment, in order for you to receive written confirmation of expected dental benefits for that treatment, which may help you budget to obtain the dental care you need. The dentist will advise you on the best treatment for you, while your insurance company will determine whether that treatment is part of your benefits, not whether it is needed for your oral health. Due to privacy laws, your insurance company generally DOES NOT contact our office. When you receive a written response from them, contact our office to make arrangements for your dental treatment. If you need clarification on this written response, our front desk team will be happy to help you.

Office Policy on Scheduled Appointments:

Your appointment time is reserved especially for you. If you need to change your appointment, please contact us with at least 2 business days notice, otherwise a fee may be applied to your account (fee is a minimum of $50, and up to $200 depending on the planned treatment for that missed appointment, and at the discretion of Aldente Dentistry). Our office considers business days to be Monday to Friday. Eg. To change a Monday appointment, please contact our office no later than the Thursday prior. Failure to give us at least 2 business days notice results in delayed treatment for you, inability of another patient to book their needed treatment, and a loss of productivity for our office and staff.

Confirmation Calls and Courtesy Reminder Calls:

Our team will work with you to help you schedule your appointments to best suit you. We will contact you a few weeks before your scheduled check up/cleaning and confirm if your scheduled appointment date and time still works for you. At this time, if you need to, we can change the date and/or the time to suit your schedule. Please let us know what mode of communication you like best (eg. e-mail, texting) so we can best communicate with you.

If you desire, our team will give you a courtesy reminder call/e-mail/text a couple of days before your scheduled appointment. Please keep in mind that this is a courtesy. Our responsibility to you as our patient is that your appointment time is reserved especially for you; your responsibility is that you will manage your schedule and keep your appointment, even if you do not get a courtesy reminder.

Patient Release:

I, the undersigned, certify that I have provided accurate and complete personal information, including medical and dental history, and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to my questions regarding my medical and dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required and I consent to this. I authorize the use of any dental photographs (not including full face images), taken of my teeth or smile, or that of my dependants, by this office for the purposes of professional publication, marketing, or education. I understand that the responsibility for payment for dental services provided by this office to myself or any of my dependants is mine and I understand the office policy on fees and the information about predeterminations. I understand the office policy on scheduled appointments . I understand the privacy policy of this office and how my personal information is used. I authorize this office to contact me using the contact information I have provided.

_____ _____

Name of Patient Date

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Signature of Patient (or Parent/Legal Guardian/Power of Attorney