



The following information is required to provide Mar Orthodontics a better understanding of your orthodontic needs and your medical history. Please complete both pages of this form and bring it with you to your exam. You can also email the form prior to your appointment to info@marorthodontics.ca.

Form fields for patient information: Last Name, First Name, Preferred Name, Address, City/Postal Code, Home Phone, Work Phone, Cell Phone, Email, Sex, Age, Birthdate, Employer, Occupation, Address, Marital Status.

Form fields for orthodontic problem description and spouse/parent/other information: Please describe the orthodontic problem in your own words, Spouse's/Parent's/Other's (complete below), First Name, Last Name, Cell Phone, Work Phone, Do you know a patient in our practice currently?, Who may we thank for referring you?

ADULT ORTHODONTICS INSURANCE INFORMATION

PLEASE NOTE: Having GENERAL DENTAL coverage does not mean you have ORTHODONTIC coverage

Form fields for patient insurance: Do you have orthodontic coverage?, Do you have Treaty Status?, Or any other government coverage?

Form fields for spouse/parent/other insurance: Does your spouse/parent/other have orthodontic coverage?, Birthdate of spouse/parent/other with orthodontic insurance info:

Form fields for patient insurance information: YOUR ORTHODONTIC INSURANCE INFORMATION, Insurance Company Name, Group/Policy/Plan Number, Certification Number/ID Number, Notes

Form fields for spouse/parent/other insurance information: Relationship to Patient, IF APPLICABLE PLEASE PROVIDE THE FOLLOWING: SPOUSE/PARENT/OTHER ORTHODONTIC INSURANCE INFORMATION, Group/Policy/Plan Number, Certification Number/ID Number, Spouse/Parent/Other's Employer's Name

Insurance Information

A dental insurance policy is a contract between the insured and the insurance company. The policy of the Orthodontic Association is to charge the patient directly for all services rendered. To assist those of you with insurance coverage, Mar Orthodontics will complete their part of a standard claim form, you will complete your part and send to your insurance company for reimbursement. After your consultation, Mar Orthodontics will forward a pre-authorization to your insurance company for approval to proceed with treatment. When treatment is started our patient contract coordinator will explain the payment/reimbursement process. If you have any further questions regarding insurance, please speak with our patient contract coordinator.



Physician's Name:

Address:

Phone:

Have you experienced any health problems? NO YES

Explain:

Any major change in your health recently? NO YES

Explain:

Are you currently under a Physician's care? NO YES

Explain:

Are you currently taking any medications? NO YES

Explain:

Are you allergic to any medications/latex? NO YES

Explain:

Have you received a blood transfusion? NO YES

Explain:

Have your tonsils or adenoids been removed? NO YES

Explain:

Have you been in a risk group for AIDS/HIV positive? NO YES

Explain:

Are you currently in good health? NO YES

Explain:

Are you experiencing or have you experienced any of these symptoms?

a. Fever NO YES

b. Sore Throat NO YES

c. Joint Pain NO YES

d. Muscle Aches NO YES

e. Severe Exhaustion NO YES

f. Sudden onset of new cough or change in existing cough NO YES

Have you been out of Canada in the last six months? NO YES

Where?

When?

Women Only: Are you pregnant or nursing? NO YES

It is important to notify staff if there is a possibility of pregnancy

Please check if you have had any of the following conditions:

Heart Murmur

Heart Surgery

Rheumatic Fever

Endocrine Disorders

Prolonged Bleeding

Anemia, Blood Disorder

Developmental Disorder

Hives/Rash

Hepatitis, Liver Disorders

Diabetes

Kidney Disease

Tuberculosis

Bronchitis

Asthma

Epilepsy

Fainting

Emotional Problems

Nervous/Anxious

Cancer

Bone Disorder

Growth Disorders

Herpes (Fever blisters)

Tonsillitis

Respiratory Allergies



Dentist's Name: _____ Address: _____ Phone: _____

Dental Specialist's Name: _____ Address: _____ Phone: _____

Frequency of dental check-ups: Twice a year Once a year Only if problems exist Date of last visit : _____

Frequency of cleanings: Twice a year Once a year Date of last visit : _____

Is there any unfinished care to be completed with your dentist? NO YES

Explain: _____

Are you frightened about dental treatment? NO YES

Explain: _____

Have you had an unpleasant dental experience in a dental office? NO YES

Explain: _____

Have you had any face or dental injuries? NO YES

Explain: _____

Have any teeth been removed? (either primary or permanent) NO YES

Explain: _____

Have you consulted an orthodontist previously? NO YES

Explain: _____

Have you had any previous orthodontic treatment? NO YES

Explain: _____

Is there a history of thumb or finger sucking as a child? NO YES

Explain: _____

Are you presently wearing an appliance? NO YES

Explain: _____

Please check if there is a history of:

Speech problems (If so, which sounds)

Clenching teeth

Jaw joint clicking

Grinding teeth

Mouth breathing:
Awake or Asleep

Muscular soreness
around head & neck

Jaw joint popping

Headaches
(more than normal)

Ringing in the ears

Jaw joint soreness

Is there any other condition or problem that you think we should know about?

Patient Signature: _____

(Parent or Legal Guardian)

Print Name: _____

Date Completed: _____

Orthodontist's Signature: _____

Date Reviewed: _____

(by Orthodontist)



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, cellular 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 patient 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 for 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.

We collect information from our patients about their health history, their family 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 for 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 or dental specialists if the patient, with their consent, had been referred by us to the other dentists or dental specialists for treatment.
- To other dentists or 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 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 staff as part of its regulatory activities in the public interest.

PLEASE REVIEW, COMPLETE AND RETURN TO THIS OFFICE.

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

Adult Patient/Parent/Guardian Signature: _____

Print Name: _____

Date Completed: _____