



**Records and Patient Information Release Form**

**Acknowledgement of receipt of our clinics' Privacy Statement**

I \_\_\_\_\_ have received, and read the clinics' Privacy Statement.  
(Print Legal Name)

**Permission of release of patient's health information to the following:**

- Please print legal name(s) (e.g.; Spouse, Guardian, Common-law, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

*\*Please note this form will be scanned into file and may be revoked at patient's request.*



## Privacy Statement

### TAKING CARE OF YOU & YOUR HEALTH INFORMATION

**Nuera Dental Center** respects your confidentiality and privacy. We are committed to safeguarding the personal information that is entrusted to us by our patients. This privacy statement outlines the practices we follow to protect your personal information.

This privacy statement applies to **Nuera Dental Center** and to any person(s) providing services on our behalf. A copy of this privacy statement can be provided to any client on request. It is also displayed in our clinic.

#### What is personal information?

Personal information is information about an identifiable individual. This can include any individual's name, home address, phone numbers (home, cell, work or any combination of these), age, sex, marital or family status, financial information, Health and Dental history.

#### How does our practice safeguard personal information?

At **Nuera Dental Center** we make every reasonable effort to ensure that your personal information is first accurate and complete. We do rely on patients to notify us of any pertinent changes, that may affect communication and relationships with the practice. We do ask for personal information updates on medical histories and demographics on a schedule, so please be aware that we will ask about this from time to time.

When you receive health services from our Practice, we will collect individually identifying health information in accordance with the provisions of the Health Information Act (HIA).

We will collect this health information directly from you, except in the limited circumstances where we are authorized under HIA to indirectly collect such information. **There are times when we may collect information from another person but only with your written consent on file.**

Our primary purpose in collecting your health information is to:

- Provide diagnostic, treatment and care services to you
- Determine or verify your eligibility for health services
- Bill your Insurance Provider for our services
- Internal management purposes

Our Practice will only collect, use and disclose your health information in accordance with the provisions of HIA.

We will also protect your health information from unauthorized access, use, disclosure, or destruction per the privacy provisions of this legislation. We use appropriate security measures when disposing of personal information, including document destruction (shredding paper and properly archiving electronic records). Covering all sensitive materials at the front, turning computer monitors with collective personal information away from any seated patient and ensuring all personal information is cleared from ops prior to seating a new patient.

For more information, please talk to our Practice Privacy Officer, Dr. Agrawal at 403-228-3088 or by email to [nueradental@shaw.ca](mailto:nueradental@shaw.ca)



### Dental Information

Name of previous dentist: \_\_\_\_\_ Date of last dental visit: \_\_\_\_\_ City: \_\_\_\_\_

Have you had any dental x rays taken in the last year?  Yes  No

Have you had complications from local anesthetic?  Yes  No

If yes, please explain: \_\_\_\_\_

Do you clench or grind your teeth at night?  Yes  No

Does your jaw ever make clicking or popping sounds?  Yes  No

Are any of your teeth sensitive to:  Cold  Heat  Sweets  Biting

Please discuss any previous experiences that make you uncomfortable coming into the dental office:  
\_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?

Another patient  Dental office  Yellow Pages  Online  Other: \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address \_\_\_\_\_ Phone Number: \_\_\_\_\_

Street

City/Prov/Postal Code

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Last

First

MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Street

City

State

Postal Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Postal Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Last

First

MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Street

City

State

Postal Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Postal Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Appointment Policy

We would like to ask for your help in providing a minimum of **TWO BUSINESS DAYS NOTICE** if for any reason you will be unable to keep your appointment.

This consideration will allow us to accommodate those patients that may be waiting for an appointment.

**If you are unable to provide notice there will be a \$75 short notice cancellation fee. Missed appointments will be \$75 per 30 minutes of appointment time. i.e one hour missed appointment = \$150**

For your convenience, we will continue to call or email you prior to your appointment to remind you of your visit.

I \_\_\_\_\_ have read & understand the above policy. Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Print Name) (day/month/year) (Patient Signature)



**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. 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 in 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, and 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.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. Patients' medical information is collected, and used for the purpose of diagnosing 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 of all of our 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 if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professionals 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. I understand I can revoke this consent at any time – in writing to Nuera Dental Center.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Patient Signature



**Patient Consent and Certification Form**

**Consent to Treatment**

I authorize Dr. Agrawal, or her qualified staff whom she designates, to perform advisable treatment, consultations, and/or radiographs as agreed upon throughout the course of treatment. If, during the course of procedures differ from what was originally contemplated, you will be provided with additional explanation of procedures, and expenses involved. I also acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained. I understand that the laws of the Province of Alberta will govern this Consent to Treatment Form.

**Consent to Anesthetic**

I consent to the administration of local anesthetic as indicated, and understand that in extremely rare circumstances paresthesia (numbness) may result from the administration of local anesthetic.

**Certification of Medical History**

I, the undersigned, certify that I have provided an accurate, and complete medical history, and have for knowingly omitted any information. I have had the opportunity to ask questions, and receive answers to any questions about my medical history. It is my responsibility to inform this office of any changes in my medical status.

**Emergency Care only Consent**

I authorize the dentist to perform procedures, and treatment, and/or consultation with or without x-rays as may be necessary. I also understand this treatment is for my immediate problem, and should not be regarded as a complete examination with resulting treatment. I understand that no guarantee or assurances has been made to me as to the results that may be obtained.

**Responsibility of Fees for Service Rendered**

I assume responsibility for fees associated with all services done by this office and acknowledge that I am responsible for the payment regardless if I have insurance or not.

*I understand I can revoke this consent at any time – in writing to Nuera Dental Center.*

Patient (Parent/Guardian) Signature \_\_\_\_\_ Date (d)\_\_(m)\_\_(y)\_\_\_



June 1<sup>st</sup>, 2018

Dear patients of Nuera Dental Center,

**Payment for Dental Services provided by Nuera Dental Center are due at time of Treatment/appointment.**

**Insurance Benefits Update: Payment of Dental Services**

- **Assignment of Dental Benefits.** Nuera Dental Center is happy to accept Assignment of Dental Insurance Benefits. Our Business Administrators will prepare and send all claims for our patients. We receive the payment from the insurance company and the remaining balance is charged to the patient. In most cases, the claim is received before the patient leaves the office and the patient pays their balance in full at the time of the appointment. If the claim does not respond right away or there are two insurance companies, we will wait for the remittance from the insurance companies and charge the credit card on file the remaining balance at that time. The receipt will be scanned for your records.

- **Non-assignment of Dental Benefits.** As per above our Business Administrators will prepare and send all claims for our patients. The insurance company, in this case prefer to pay the patient directly. The patient pays Nuera Dental Center at the time of the appointment. The copy of the completed insurance claim is given to the patient along with the receipt of payment for their records and the insurance payment will be remitted directly to them via mailed cheque or electronic funds transfer (EFT) from the insurance provider.

- **No Insurance.** I acknowledge that I am responsible for payment of all services rendered to me by Nuera Dental Center at the time of appointment.

I \_\_\_\_\_ have read, understand and agree to the above process of payment of dental services to Nuera Dental Center.

We can mail the receipt if you wish as we no longer email receipts ( Yes / No ).

\_\_\_\_\_  
Credit Card Number    Visa or Mastercard

\_\_\_\_\_  
Expiration Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Revocation of this agreement can be submitted to Nuera Dental Center in writing at any time.  
**Some conditions may apply.**