JOURDAIN DENTAL CARE
3249, 150 Millrise Blvd SW
Calgary, AB T2Y 5G7
(403) 201-0115

Medical Alert for Office Use

Thank you for visiting us at Jourdain Dental Care. We would like to make your visit as pleasant and comfortable as possible. Please help us by completing this form to the best of your ability. Feel free to ask us if there are any questions.

How did you hear about us? _____

What is the reason for today's visit? _____

Patient Information

Name: _____
Last First Middle Initial (Preferred Name)

Address: _____
Apt. No. Street Address

_____
City Province Postal Code

Phone: ( ) _____ ( ) _____ Email: _____
Home Work

( ) _____ ( ) _____ Date of Birth: _____
Mobile Other Day Month Year

Employer: _____ May we contact you at work? ☐ Yes ☐ No

Emergency Contact Information

Name: _____ ( ) _____
Last First Phone

General Consent for Treatment and Privacy Policy (In Accordance with the Alberta Personal Information Protection Act)

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 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. Collectively referred to as "Medical Information". Patient's Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patient's 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 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 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.

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 authorize and give consent to perform dental services agreed upon between myself and the doctor/auxiliary staff of Jourdain Dental Care. I certify that, to the best of my knowledge, the information provided in my Health History is accurate and correct. If I ever have any changes in my health, I will inform this clinic at the next appointment without fail. I consent to the collection, use and disclosure of my personal information as set out in the office Privacy Policy.

Patient Signature: _____ Date: _____

Guardian Signature (If Patient is Under 18): _____