Vista Dental care

WELCOME TO OUR PRACTICE

On behalf of the entire team at Vista Dental Care, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional, and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received.

In order to better serve you, we are enclosing in this Welcome Packet several important documents that will assist us in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Registration and Medical History that should be filled out prior to your first appointment with us.

Be sure to visit our website at vistadentalcare.ca. We look forward to serving all your dental needs for you and your family.

Yours truly for better dental health,

Dr. Chad Aitken, DMD

Vista Dental care

(855) 636-9223
280-5201 43 St.
Red Deer, AB T4N 1C7
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Child's Registration and Medical History

Your child's complete oral health is our main concern. Communication is key to helping us give your child a happy, healthy smile. We therefore ask that you complete this form in its entirety.

1 About Child

Today's Date:_____

Name:_____
LAST FIRST MI

Nickname:_____ ❑ Male ❑ Female

Birthdate:__/__/__ Age:_____ SS #:_____

Home Address:_____
APT / CONDO #

_____
CITY STATE ZIP

Home #: (___)_____ Cell #: (___)_____

Where and when are best times to reach you?_____

Whom may we thank for referring you?_____

Other family members seen by us:_____

2 Parent Information

Father's Name:_____

Birthdate:__/__/__ Age:_____ SS #:_____

Employer:_____

Home #: (___)_____ Cell #: (___)_____

Work #: (___)_____ Ext:_____ DL #:_____

Mother's Name:_____

Birthdate:__/__/__ Age:_____ SS #:_____

Employer:_____

Home #: (___)_____ Cell #: (___)_____

Work #: (___)_____ Ext:_____ DL #:_____

Person Responsible for Account:

Work #: (___)_____ Ext: ____ Home #: (_____

Billing Address: _____

Relation: _____ SS #: _____

Employer:_____ DL #: _____

ARE YOU ON MEDICAID?..... ❑ YES ❑ NO

DO YOU HAVE DSHS COUPONS?..... ❑ YES ❑ NO

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, who should be notified, other than a parent?

Name:_____ Relation:_____

Address:_____

Work #: (___)_____ Home #: (_____

4 Medical History

Does your child have a personal physician?..... ❑ Yes ❑ No

Physician's Name: _____

Phone #: (___)_____ Date of last visit: _____

Is the child currently under the care of a physician?..... ❑ Yes ❑ No

Please Explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY continued

Date of last physical:_____

Child's current physical health is:..... ❑ Good ❑ Fair ❑ Poor

Is child taking any prescription, over-the-counter, or supplement drugs? ❑ Yes ❑ No

Please list each one:_____

_____

Does your child smoke or use tobacco in any other form?.....❑ Yes ❑ No

Has your child ever had any of the following diseases or medical problems? (Please check all that apply):

❑ Aids or Other Immunosuppressive Disorders
❑ Allergies to Anesthetics
❑ Allergies to Medicines or Drugs
❑ Asthma
❑ Artificial H art Valves or Joints
❑ Bladder Problems
❑ Cerebral Palsy
❑ Chemical Dependency
❑ Convulsions
❑ Diabetes
❑ Epilepsy
❑ Hearing Problems
❑ Heart Problems
❑ Hemophilia
❑ Hepatitis, Jaundice, or Liver Disease
❑ Kidney Problems
❑ Mononucleosis
❑ Radiation Treatment
❑ Rheumatic Fever
❑ Thyroid Problems
❑ Tuberculosis

Please list any serious medical condition(s) that your child has had:

_____

_____

Is your child allergic to any of the following?

❑ Aspirin
❑ Codeine
❑ Dental Anesthetics
❑ Erythromycin
❑ Jewelry/Metals
❑ Latex
❑ Penicillin
❑ Tetracycline
❑ Other

Please list any other drugs/materials that child is allergic to:_____

_____

We appreciate your effort to fi l out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

Our office is Privacy Act Compliant and committed to meeting or exceeding the standards of infection control mandated by ADA&C.

5 DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

_____

When was child's last dental visit?_____

Experiencing any discomfort now?_____

Do you desire complete dental service for your child?_____

Has your child ever responded adversely to medical or dental treatment?

_____

Has your child ever been on or has any physician ever told you your child needs to have premedication before dental work?.....❑ Yes ❑ No

Is there anything else we should know about child's dental history?_____

_____

How many times a week does child floss?_____

How many times a day does child brush?_____

Type of bristles? ❑ Hard ❑ Medium ❑ Soft

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confiden e, and it is my responsibility to inform this offi e of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

_____

Relationship to child

Payment is due in full at the time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: Date:

Vista Dental care

APPOINTMENT AGREEMENT

At Vista Dental Care, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 48 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 48 hours, you will be subject to a $50 late cancellation charge.

We truly appreciate your understanding. Our goal at Vista Dental Care is to be your partner in health and to assist you in keeping your teeth for a lifetime.

By signing below, I agree to fulfill my obligation as a patient at Vista Dental Care and agree to the "broken appointment" fee should I not give proper notification.

_____ _____

Signature of patient or responsible party Date

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YOUR d En TAL n EEd S

Your Name: _____ Date: _____

Our office is like no other dental office. This will be the most important dental visit you will ever have. We place a high emphasis on helping you determine your present and future dental needs. Some things we will discuss during your first visit may be issues you have never considered before. Please check what best expresses how you feel about the following questions:

• Are you having any areas of concern? _____

• What do you think is the present state of your oral health? _____

_____

• What do you already know about our office and what are your expectations? _____

_____

• How healthy do you want us to get your mouth? (please circle)

The best it can be Average Don't really care

• Should you need treatment, at what point should we address it? (please circle)

When something isn't ideal When something is worsening When my tooth hurts or breaks

• What quality of dentistry do you want us to recommend? (please circle)

Ideal/the best Average Just patch it

• We have the ability to look at your mouth from three different perspectives. Please rank these in the order of most important to least important to you.

___ As a general dentist ___ As a cosmetic dentist ___ As a functional dentist

• How do you feel about the appearance of your face and smile? _____

_____

• What would it take for you to trust us to be your dentist? _____

_____

• Tell us about your good dental experiences. _____

• And the bad ones. _____

• Has fear ever been an issue for you in a dental office? _____

• What caused you to leave your last dental office? _____

• Has time ever been a factor in getting your dental work done? _____

• Has cost of dental treatment been a concern for you? _____

• What can we do to help you with this? _____

• Is there any additional information you would like us to know? _____

Vista Dental care

COMFORT MEn U

Your comfort is our priority. We provide a variety of services to ensure that you are comfortable at all times. Please select from the following options:

• Patients find that if they take an analgesic prior to treatment it helps later in the day.
Which would you prefer? Tylenol Advil Other _____

• We provide various levels of sedation to ease your mind.
Would you benefit from a sedative?.....Yes ❑ No ❑

If yes, we provide: ❑ Nitrous Oxide (laughing gas)
❑ Mild sedative (oral medication) With mild sedative, you will need someone to drive you to and pick you up from the appointment.

• Our treatment rooms are equipped with cable TV and DVD players. Watching TV or a movie is an excellent way to pass the time during your visit. Please let us know what your favorite movie or TV show is, and at your next appointment we will make sure we have it for you to watch.

• Complimentary WiFi Internet access is available for your use throughout the office. Please feel free to bring your wireless Internet device with you for each visit.

• Blankets help keep you warm and relaxed through your visit.
Would you like a blanket?.....Yes ❑ No ❑

• Pillows provide an extra measure of comfort if you have a sore back or neck.
Would you like a pillow?.....Yes ❑ No ❑

• Is there anything else we can do for you to make your visit comfortable?

_____

_____

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Vista Dental care

SOME THINGS YOU SHOULD KNOW ABOUT DENTAL BENEFITS

At Vista Dental Care, we believe that you deserve the best care. hat's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of folks. Some have dental benefits, but most don't. If you have dental benefits, congratulations! You are very fortunate. If you don't, we have numerous ways to make any type of dental care affordable for you. Here are some important things you should know if you do have dental benefits…

Your dental benefits are based upon a contract made between your employer and an employee benefits company. If you have any questions regarding your dental benefits, please contact your employer or the benefits carrier directly.

Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of $1,000. You'll be surprised to know today that the average dental benefit plan has a yearly maximum cap of $1,000. There has been no significant increase in the yearly maximum cap in 50 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It has always been meant to assist you.

Many people receive notification from their insurance company that dental fees are "above usual and customary." A dental benefits company determines their reimbursement level by surveying a geographical area and calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discount dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that dental benefit companies define as "*higher than usual and customary.*"

Many dental benefit plans tell their participants that they will be covered "up to 80% or 100%" but do not clearly specify the plan fee schedule allowance, annual maximum, or limitations. It is more realistic to expect dental benefit plans to cover between 25% to 40% of dental services. Remember that the amount a plan reimburses is determined by how much your employer has paid for your dental benefit plan. You will get back only what your employer has put in, less the insurance company's profit margin.

Dental benefit companies do NOT cover many routine and newer dental services.

Our team members will gladly assist you in filling out the necessary forms to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We hope you will choose the best that dentistry has to offer.

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INSURANCE CLAIMS PROCESS

Our office is pleased that you have insurance benefits to help you with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so that we can work together to ensure this benefit.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?
We currently accept all private care insurance (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL. WHY?
We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to visiting our office, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so that we may adjust accordingly.

INSURANCE DIDN'T PAY. NOW WHAT?
We bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due you. This is rare, but it is important that you recognize the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS
Our office does request payment in full for your estimated portion at the time of service. All accounts not paid in full after 60 days will be charged a finance charge at a rate of 2% per month (24% per annum). If you are in need of an extended option, please just ask one of the patient services staff for an application.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at your office, Vista Dental Care.

Name:_____Date:_____

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Vista Dental care

FINANCIAL MENU

We consider our relationship with you to be of primary importance and will always make our recommendations based on what we believe is the very best treatment for you, regardless of your insurance coverage or financial arrangements. For your comfort and convenience, we offer a wide range of financial options and welcome your suggestions and questions.

A) Split Payment

Half of the total treatment is due at the preparation visit, and the second half is due the day of cementation of the crowns/bridges/veneers.

B) Pre-Authorized Credit Card Agreement

With your permission and signature, we will charge your Visa, MasterCard, or Interac with an agreed payment amount each month. his allows you to make monthly payments without applying for additional credit.

C) Pay as You Go

You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

D) Prepayment in Full (For treatment over $2000)

A prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

E) Dental Card Plan

With fast approval over the phone from Dental Card, your payment can be much lower than those available through our office. Dental Card specializes exclusively in helping patients with larger dental cases to receive the treatment they want. Dental Card carries fixed rates and can extend terms out to 60 months. here is no prepayment penalty. We will assist you in contacting them from our office.

F) **Gradual Treatment Plan**

FOR THOSE PATIENTS ON A LIMITED BUDGET. By prioritizing treatment, those patients who do not have dental insurance or are on a tight budget can still complete their dental work by spreading appointments over several months or years.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, Interac, Discover, Money Order, Personal Checks, or Dental Card Plan (see above).

I understand that if I become delinquent on my account, my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect on this account.

I certify that I have read, fully understand, and accept the above financial policy.

Signature:_____ Date:_____

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FINANCIAL POLICIES

Here at Vista Dental Care, our office policy regarding financing is as follows: As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment.
he practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient/patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the management's discretion, for payments in full with cash or money order. (Inquire for more details.)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan.

A service charge of 2% per month (24% per annum) on any unpaid balance will be charged on all accounts exceeding 60 days from date of service, unless previously written financial arrangements are agreed upon and satisfied. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, I agree to pay the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time allotted for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to Vista Dental Care and/or Vista Dental Care's financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

_____ Date:_____ Relationship to Patient:_____

Signature of patient, parent or guardian

_____ Date:_____ Relationship to Patient:_____

Signature of guarantor of payment/responsible party

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Social Security # _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (941) 758-4543 or by mailing us at 280-5201 43 St., Red Deer, AB T4N 1C7.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.