Walden Orthodontics
Dr. Angela Sharma
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Certified specialist in orthodontics
Ph: 587.393.6020 Fax: 587.393.6021
The Smile You Always Wanted

PATIENT INFORMATION

☐ Mr ☐ Mrs. ☐ Miss ☐ Ms. ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Name _____
Last First Middle

Address: _____
City Province Postal Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: (circle) Female Male
dd mm yy

Employer: _____ Occupation: _____

Email:_____ Spouse's Name_____

Are other family members patients at our office: (circle) Yes No

Would you like appointment confirmations via text messaging or email? (circle) Email Text Message

Who can we thank for your referral to our office? (please circle) _____

Family Friend Brochure Newsletter Live Close By Internet Website Signage Other

INSURANCE INFORMATION

Name of Primary Policy Holder	**Date of Birth** dd/mm/yy	**Primary Insurance Company**	**Group Policy Number**	**ID or Certificate Number**
Patient's relationship to policy holder:	☐ Self	Spouse ☐	Child ☐	Other ☐

Name of Secondary Policy Holder	**Date of Birth** dd/mm/yy	**Secondary Insurance Company**	**Group Policy Number**	**ID or Certificate Number**
Patient's relationship to policy holder:	Self ☐	Spouse ☐	Child ☐	Other ☐

****PLEASE NOTE: EVERY INSURANCE POLICY IS DIFFERENT AND INSURANCE BENEFIT BOOKLETS ARE GUIDELINES ONLY. IT IS THE RESPONSIBILITY OF THE POLICY HOLDER AND PATIENT TO KNOW YOUR POLICY COVERAGE, NOT THE RESPONSIBILITY OF THE DENTAL OFFICE.**

IMPORTANT CONTACTS

In case of emergency, notify:	Relationship	Phone Number
Family Physician	Clinic Name and/or Address	Phone Number

WALDEN ORTHODONTICS

Personal Information Privacy Act

We are committed to protecting the privacy of our patients' personal information and to use all personal information in a responsible and professional manner and disclose personal information only when permitted or required by law.

Personal Information Procedures
We receive contact, medical and financial information about our patients such as names, home/work addresses, home/work phone numbers, e-mail addresses, date of birth, insurance plan details, health/dental histories, emergency contact information.

Contact information is disclosed to third party health benefit providers and insurance companies, with the CONSENT OF THE PATIENT for purposes of submission of claims, reimbursement or payment of dental care, predetermination of dental treatment, open and update patient files, invoice patients for dental services, process dental claims, and to send reminders to patients concerning the need for further dental treatment.

Medical information is disclosed, with consent of the patient, to other dentists, dental specialists, or health care professionals such as physicians. It is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Financial information is collected for payment processing purposes. It is not shared with third parties unless permitted by law for outstanding bill collection purposes.

Insurance Policy Matters

I am aware that Walden Family Dental does not accept assignment from my insurance company. The dental office accepts **no responsibility** for any uncovered amounts, amounts over allowed benefit maximums, plan limitations or restrictions, etc. Walden Orthodontics has advised me that I make myself aware of my dental plan and know my coverage. My dental insurance policy is an agreement between me and my insurance company. The insurance company does not permit releasing any information to the clinic due to the Health Privacy Act. We want to make you aware of this fact. Dental providers usually receive payments four weeks after treatment and sometimes longer if you have more than one insurance plan. **Please note that every insurance policy is different. It is the responsibility of the policy holder and the patient to know your policy coverage. It is NOT the responsibility of the dental office.**

Please remember that under no circumstance is it customary for an insurance company to cover a dentist's fee in full. Our fees are reasonable and competitive according to Alberta Dentists Association Standards. **You are responsible for payment regardless of your insurance company's determination of the amount.**

Please keep track of you yearly maximums, limitations, appointment dates and accumulated amounts used on your dental plan. Walden Orthodontics has advised me to contact my plan provider should I have any questions.

Thank you for understanding our policy. Please let us know if you have any questions.

I consent to the collection, use and disclosure of my personal information as set out above and that of my dependents. I authorize Walden Orthodontics to keep my signature on file to charge any credit/debit memos, as well as outstanding payments in the event of short-notice cancellation/missed appointment and remaining balances after my insurance claims have been paid, to my credit card. I agree to keep Walden Orthodontics updated with a current credit card and inform of any changes in my insurance following treatment. This credit card information will be kept on a separate confidential file that is secure. A receipt will be emailed to you if provided.

Signature of Patient: _____ Date: _____