FAMILY DENTAL CENTRE

#301, 4015 - 17 Avenue S.E.
Calgary, AB T2A 0S8
PH: 403- 272-1500 FAX: 403- 569-2162

PERSONAL INFORMATION

Our office is dedicated to protecting your privacy in a professional and responsible manner. This form summarizes the personal information that we collect, use and disclose. In addition to the circumstances described in the form, we also collect, use and disclose personal information when permitted or required by law.

We retain personal information such as, names, home addresses, home telephone numbers, work telephone numbers, and cell numbers. Other personal information we collect may include policy and ID numbers, in order to process your claims. This includes financial information as well. This personal information is collected and used for the following purposes:
- To open and update patient files
- To invoice patients for dental serviced, to process credit card payments, or to collect unpaid account.
- 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 for treatment.
- To send patients informative material about our dental practice.

Personal information may be 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 their behalf.

We collect information from our patients about their health history, their family health history, physical condition, and previous dental treatments. Patient's medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. Professionals we may disclose information to are:
- To insurance companies where the patient has submitted a claim for reimbursement or payment 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 other dentists and dental specialists where those dentists have asked us, with 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, for either a second opinion or treatment.

ASSIGNMENT OF BENEFITS

For your convenience this office is willing to accept direct payment from your dental plan for the cost of dental services which we may provide and which your plan covers.

Due to numerous and varied plans it is impossible for us to know the details of them all. Your plan may or may not cover all the costs you incur for your treatment. You are however, responsible for any unpaid portion that your plan does not pay.

CONSENT

I hereby consent to the performing of the Dental and Oral Surgery procedures necessary or advisable for the above named patient as outlined, including the use of Local Anesthesia or Nitrous Oxide, Oxygen Inhalation Anesthesia as indicated, and I accept responsibility for the fee.

I authorize my insurance company plan administrator to release the information contained on my Dental Claim

I hereby assign my benefits payable from claims submitted electronically and authorize payment directly to Family Dental Centre.

X_____

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Signature of Patient/Parent or Guardian Date