"We want to make you smile!"

Personal Information Form

Dr. Julie Labbé General Dentist

Contact Information

Patient Name: _____

DOB (day/month/year): _____

If the patient is a child, please provide parent(s) names ore legal gardian : _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ e-mail address: _____

What is your preferred method of contact?: _____

Insurance Information

Primary Dental Insurance co.: _____

Policy #: _____ ID#: _____

Spouse/Common Law/Partner's Name: _____

Dental Insurance co.: _____

Policy #: _____ ID#: _____

Emergency Contact Information

Your Emergency Contact Person: _____ Phone: _____

Referrals

Who may we thank for referring you?: _____

Personal Information Consent

Our office is committed to protecting the privacy of our patient's personal information and to use the information that you provide us in a professional manner.

The contact information that we collect is used in the following way; We use it to open and update your files. We also use it to process claims on your behalf with your insurance provider. If requested by you, we can send your insurer predeterminations as to what dental treatment you require. We will contact you to remind you of upcoming appointment times and concerning scheduling your next exam and cleaning.

The medical and dental information we collect is used for the purpose of treating you. All information collected is relevant to your safe dental care. The dental information is shared with your insurance provider if you ask us to submit a claim for reimbursement on your behalf. Dental information and pertinent medical information may be shared with other dentists or specialists that are involved in providing you treatment and with your physicians in cases where their professional knowledge is necessary to our treating you properly.

All dental offices in Alberta are regulated by the Alberta Dental Association and College and may be subjected to inspections by them or Public Health. Records may be confidentially inspected as part of those regulatory activities and it is done in the public interest.
I, _____ , consent to the collection, use and disclosure of my personal information as set out above.
This authorization shall continue in effect as long as I am a patient at this office, unless I revoke it.

Signature: _____ Date: _____