## PATIENT INFORMATION I Please Print Clearly

Find us on f

Patient full name: ____________________

Preferred name: ____________________

Birth date (MM/DD/YY): ____________________

Mailing address: ____________________

City: ____________ Province: ____________ Postal code: ____________

Home phone#: ____________ Cell phone#: ____________

Work phone#: ____________ Email: ____________

Emergency contact name and #: ____________________

If applicable, name and number of main contact for patient (if the patient needs assistance or has a power of attorney):

____________________

____________________

Personal health care #: ____________________

Primary insurance company: ____________________

Group/policy#: ____________ ID/certificate#: ____________

Secondary insurance company: ____________________

Group/policy#: ____________ ID/certificate#: ____________

Spouses name (for insurance purposes only if spouse is the main cardholder):

Spouses birthdate (MM/DD/YY): ____________________

By signing here, you are giving Mile Zero Denture Clinic the right to contact your insurance company on your behalf.

Signature: ____________ Date: ____________

## HOW DID YOU HEAR ABOUT OUR CLINIC? Please specify name:

____________________

____________________

____________________

Are you allergic to any metals, latex or acrylic?: ____________________

Any other allergies?: ____________________

Name of dentist?: ____________________

Age of existing denture?: ☐ 0-4 Years ☐ 5-9 Years ☐ 10+ Years

Type of denture? (check all that apply): ☐ Complete Upper ☐ Complete Lower ☐ Dental Implants

☐ Partial Upper (metal framework) ☐ Partial Lower (metal framework)

☐ Acrylic Partial Upper (no metal) ☐ Acrylic Partial Lower (no metal)

# Mile Zero Denture Clinic Privacy and Billing Policies

NOTE TO CLIENT: We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with the personal information we obtain about you. If you have any questions with regard to our privacy policy, please ask.

## CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with the denture health care goods and services, the denturist will collect some personal information about me like, but not limited to, home address, telephone number, and medical history.

I understand that in accordance with this denturist's Privacy Policy, the collection and disclosure of my personal information will be protected and remain within the scope of this denturist's practice. I understand and agree that the denturist may use my address and telephone number to communicate to me within the scope of practice and in relation to the provision of denture health care.

I understand how the privacy policy applies to me and I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

SIGNATURE__________________________________________ DATE_____________________________

## BILLING POLICIES

**For Complete, Partial and Implant Dentures a 50% Deposit is required at the start of treatment,** (impression appointment). The remaining balance will be paid in full at the second last appointment, (Try-in appointment).

**For Immediate Dentures, Relines and Repairs, full payment will be required at the first appointment. (All insurance claims will be sent in and payment issued to patient)**

As a courtesy to our patients we will assist you with submitting insurance paperwork, which includes: pre-authorizing treatment plans and sending in claims. It is however the responsibility of you (the patient) to ensure treatment payment is made. * **A pre-authorization must be in place before we will begin treatment. The portion that your insurance company does not pay is due at the time of your first appointment, (impression appointment).**

**We do not direct bill immediate dentures or repairs; payment is required up front, we will send in the insurance claim and payment will be issued to the patient.**

* First Nations and Inuit Health (FNIH):
*We no longer accept pre-authorizations for FNIH, all procedures will have to be paid as per outlined above. We will submit a claim for you and all monies will be directed to you.

As a service to our patients we provide you with a **Warranty** when you receive your denture. It is your responsibility to receive the necessary service within the time frame spelled out in the warranty.

I have read and understand the above policies.

Signature:______________________________________________________ Date:___________________________________________