PATIENT REGISTRATION

Canadian / Alberta dental intake form

Secure portal submission

Do not send by regular email

Collection notice - Alberta Health Information Act

The clinic collects the information on this form under Alberta's Health Information Act for patient identification, scheduling, dental care, billing, benefit claims, and legally required patient records. Only information reasonably necessary for these purposes is requested. The clinic will protect, use, and disclose it only as permitted by law. Questions about collection may be directed to the clinic Privacy Officer.

Privacy Officer: [NAME / TITLE] Phone: [PHONE] Email: [SECURE CONTACT] Address: [CLINIC ADDRESS]

1. Patient details

Legal first name *

Middle name

Legal last name *

Preferred name

Date of birth (YYYY-MM-DD) *

Patient record number (clinic use)

Patient is

- ☐ Adult
- ☐ Minor
- ☐ Other / substitute decision-maker involved

2. Contact and address

Primary phone *

Email

Preferred appointment contact

- ☐ Phone call
- ☐ Text message
- ☐ Email

Street address *

Unit / apartment

City / town *

Province / territory *

Postal code *

3. Parent, guardian, or substitute decision-maker (when applicable)

Full name

Relationship to patient

Phone

Email

4. Emergency contact (optional)

Full name

Relationship

Phone

Not collected: Social Insurance Number (SIN), Social Security number, driver's licence number, marital status, and employer address are not requested on this form.

DENTAL BENEFITS & ACKNOWLEDGEMENTS

5. Dental benefit plan (complete only if the clinic will submit claims)

Do not provide a SIN. Enter only the identifiers shown on the dental benefits card or insurer portal.

Primary plan

Plan holder full name

Relationship to patient

Insurance company

Group / policy number

Member / certificate ID

Plan holder date of birth (if insurer requires)

Secondary plan (optional)

Plan holder full name

Relationship to patient

Insurance company

Group / policy number

Member / certificate ID

Plan holder date of birth (if insurer requires)

☐ I authorize the clinic to submit dental benefit claims and exchange only the information reasonably necessary for eligibility, claim adjudication, coordination of benefits, and payment. I understand this authorization can be withdrawn in writing, subject to legal and contractual limits and claims already processed.

6. Communication choices

Appointment and care-related communications may contain limited personal information. Select the methods the clinic may use. Standard carrier or email risks may apply outside the secure portal.

☐ Leave voicemail with appointment details

☐ Send text reminders

☐ Send email reminders

☐ Use secure patient portal

7. Patient acknowledgement

I confirm that the information I provided is accurate to the best of my knowledge. I acknowledge that I have received the collection notice above and understand that I may ask the clinic to access or correct my information. This form does not replace consent discussions for treatment.

Patient / parent / guardian / authorized representative name *

Relationship (if not patient)

Electronic signature / initials *

Date (YYYY-MM-DD) *