Patient Information

Last Name_____First name_____Age ___Sex___Birthdate(M/D/Y)_____
Address_____City_____Postal Code_____
Home Phone_____Work Phone_____Cell Phone_____
Employer_____Occupation_____
Parent/Guardian/Spouse_____Phone_____
Family Doctor_____Phone_____
Previous Dentist_____Phone_____
Referred By_____email_____

Insurance Information

Alberta Health Care # _____Max_____Recall Frequency_____
Primary Dental Insurance_____Effective Date_____Group/Policy#_____Div_____
Subscriber's Name_____Date of Birth_____ ID#_____Late Entry?____
%Coverage - Preventive_____Basic_____Major_____Ortho_____Deductible_____
Secondary Insurance_____Effective Date_____Group/Policy#_____Div_____
Subscriber's Name_____Date of Birth_____ ID#_____Late Entry?____
Employer_____Phone_____Max_____
%Coverage - Preventive_____Basic_____Major_____Ortho_____Deductible_____

Medical History

Have you ever been diagnosed or treated for any of the following conditions:

1. Cardiovascular		2. Digestive Problems		3. Breathing and Lungs	
Heart Attack	Y/N	Crohn's Disease	Y/N	Hay Fever	Y/N
Heart Disease	Y/N	Ulcerative Colitis	Y/N	Sinus Problems	Y/N
Heart Murmur	Y/N	Celiac Disease	Y/N	Tuberculosis	Y/N
Angina(chest pain)	Y/N	Ulcers	Y/N	Asthma	Y/N
Stroke	Y/N	GERD/Acid Reflux	Y/N	Emphysema	Y/N
Arrhythmia	Y/N	Liver Disease	Y/N	C.O.P.D.	Y/N
High/Low Blood Pressure	Y/N			Persistent Cough	Y/N
Rheumatic Fever	Y/N				

4. Blood Disorders		5. Metabolic Disorders		6. Viral Ailments	
Hemophilia	Y/N	High Cholesterol	Y/N	Hepatitis A B C	Y/N
Anemia	Y/N	Diabetes	Y/N	AIDS / HIV	Y/N
Leukemia	Y/N	Thyroid Disorder	Y/N	Cold Sores	Y/N
Prolonged Bleeding	Y/N	Osteoporosis	Y/N		

7. Other Conditions

Epilepsy	Y/N
Arthritis	Y/N
Glaucoma	Y/N
Migraines	Y/N
Bulimia	Y/N

Please list all medications including prescriptions, over-the counter and natural health products _____
_____
_____
_____
_____**continued on other side**

Cancer	Y/N	Have you experienced an allergy to any of the following:		
Substance Abuse	Y/N	Metals	Local Anaesthetics	Latex
Smoking	Y/N	Aspirin	Ibuprofen (Advil/Motrin)	Sulfites
Hearing Impairment	Y/N	Penicillin	Codeine	Sulfa
Methemoglobinemia	Y/N	Acetaminophen (Tylenol)		
Psychiatric Illness	Y/N	Other:_____		
Pregnant/Breastfeeding	Y/N	Notes:_____		
Kidney Disease	Y/N	_____		
Radiation/Chemotherapy	Y/N			

Dental History

1. Have you ever had a bad dental experience?_____
2. Have you ever had complications following dental treatment?_____
3. Do you have trouble getting numb or have had reactions to dental anaesthetics?_____
4. Sore or bleeding gums?_____ 5. Sensitive teeth?_____
6. Have you had teeth removed before?_____
7. When was your last visit to the dental office?_____
8. The reason for my appointment today is_____

Patient (Parent) Consent

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, and I will be responsible for fees associated with those procedures. Also, I agree to pay for any amounts not covered by my dental plan.

_____ _____

(Date) (Signature)

Privacy Statement and Personal Information Protection Consent

We are committed to protecting our patients' personal information and using this information in a professional and responsible manner. This form details some of the personal information we collect, use and disclose. In addition to this document, there are some circumstances when we are required to disclose personal information by law.

Personal and/or Financial Information may be collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, process credit card payments, or to collect unpaid accounts.
- To process claims from third party health benefit providers and insurance companies.
- To send reminders to patients regarding the need for further treatment, or for any promotional correspondence.

Contact information is disclosed to third party benefit providers or insurance companies where either the patient has submitted a claim for reimbursement for the cost of dental treatment, or when we are asked to submit a claim on their behalf. We also collect medical information from our patients which includes the health history, family health history, current health condition, and dental history. This information is used for the purpose of properly diagnosing and providing dental treatment.

Medical information is disclosed:

- To third party health benefit providers and insurance companies when submitting a claim on the patient's behalf
- To other dentists and dental specialists when required to obtain a second opinion or for referral of specialty treatment, with the prior consent of the patient.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us for either consult, second opinion, or treatment.

If we are ever considering selling our practice, qualified potential purchasers may be granted access as part of the due diligence process, and we will ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College which may inspect our records as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal information as set out above

_____ _____ _____

(Date) (Print Name) (Signature)