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Personal Information

Patient Name:_____Date of Birth (D/M/Y): _____/_____/_____

Mailing Address: _____Postal Code: _____

Telephone (Home): _____ (Work): _____ (Cell):_____

Email:_____Alberta Health Care #:_____

Who may we thank for referring you to our office?_____

Emergency Contact _____Relationship_____Phone #_____

Preference for Appointment Reminders: ___ Text ____Phone ____Email

Do you have dental insurance? ☐ Yes ☐ No (Please provide information to front desk staff)

**Please ensure that you notify our office to any changes in your insurance policies.

Medical History

Date of last complete Medical Examination? _____Family Doctor: _____

List any medications that you are currently taking:_____

_____

Do you have any allergies to drugs or medication?_____

Have you had any of the following? (Please Circle)

Latex sensitivities	Blood transfusion	Kidney Trouble	Rheumatic / Scarlet Fever
Artificial joints	Prolonged Bleeding	Liver Disease	Epilepsy or Seizures
Heart surgery	Bruise easily	Hepatitis A / B / C	Dizziness/Fainting
Heart Disease	Anaemia	Stomach/Intestinal Problems	Mental /Nervous Disorder
Artificial Heart valve	Lung Disease	Ulcers	Glaucoma
Heart murmur	Asthma, Hay fever, or Allergies	Diabetes	Thyroid Problems
Pacemaker	Emphysema	Tumours or cancer	Chronic Fatigue
Heart attack	Tuberculosis	Chemotherapy	Vitamin/mineral therapy
Chest pain /shortness of breath	Smoke or oral tobacco	Radiation therapy	Major Operations
Stroke	Snoring	STD	Shingles
High / Low Blood pressure	Tonsil/adenoid problems /surgery	A.I.D.S. / H.I.V. Positive	
Haemophilia	Sinus Conditions	Arthritis/Rheumatism	

Are you currently under the care of a medical specialist for any conditions? ☐ Yes ☐ No

Explain:_____

For Women Only	Y	N	
Are you pregnant?	☐	☐	Due Date? _____
Are you nursing?	☐	☐	

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Dental History

Date of last dental visit:_____Name of last Dentist (office):_____

Have you had recent Dental x-rays? ☐ Yes ☐ No When? _____

How often do you brush your teeth?_____Floss?_____

What other dental aides do you use? (Example: Sonicare, Braun, toothpick, proxybrush, endtuft, etc.):

_____

Have you ever had?	Y	N		Y	N
Orthodontic treatment?	☐	☐	Have you had general anesthesia?	☐	☐

Has your previous dentist ever had difficulty with freezing you (numb)? ☐ Yes ☐ No

Have you ever been told you need antibiotic premedication prior to dental treatment? ☐ Yes ☐ No

	Y	N		Y	N
Do you have bleeding gums?	☐	☐	Do you presently have decay?	☐	☐
Do you presently have broken or missing teeth?	☐	☐			

Where?_____

Are any of your teeth sensitive to**:** ☐ Hot ☐ Cold ☐Sweets ☐ Biting or Chewing?

Do you have cold sores, blisters, or any other oral lesion? ☐Yes ☐No

Do you have active dental problems now? ☐Yes ☐No - Please explain:

_____

Personal Smile Evaluation:

Are you interested in any of the following?

☐ Whiter teeth ☐ Straighter teeth ☐ Enhancing your smile

Occlusal Habits:

☐ Clench or grind your teeth ☐ Day ☐ Night ☐ Chew Gum ☐ Notice your front teeth hit first
☐ Bite Pencils ☐ Bite your cheek ☐ Smoke a pipe
☐ Bite your nails ☐ Notice your jaw is tired in the morning

Headaches:

Migraines ☐ Tension Headaches ☐ How often?_____

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No

If so, please describe _____

_____

AUTHORIZATION: I, the undersigned, do hereby authorize and consent to the administration of all dental procedures deemed necessary or advisable for myself, or my child, including, but not limited to, the use of local anaesthetics, or other prescribed medication.

I shall assume responsibility for payment of all fees associated with the said procedures. I have reviewed the foregoing consent and authorization, and understand its contents.

Relationship to Patient (ie; Self / Mother): _____

_____

Print Name of Patient / Parent / Guardian Signature Date

_____

Dentist Signature Date

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Dental Office Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone number, work telephone numbers and e-mail addresses. (Collectively referred to as "Contact Information"). Contact Information is collected and used for the following purposes:

- To open and update patient files
- Invoice patients for dental services, to process credit card payments, or to collect unpaid accounts
- 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 or treatment
- To send patients informational material about our office, dental materials and services
- To follow up with treatment and/or customer service

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patients' behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition and dental treatments. (Collectively referred to as "Medical Information"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. Patients' Medical Information is disclosed for the following purposes:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment, or the patient has asked us to submit a claim on their behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining a second opinion
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment
- To other dentists and dental specialists where those dentists have asked us, with the 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 to the other health care professional for either a second opinion or treatment

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access, as part of the due diligence process, to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff 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.

Print Name of Patient / Parent / Guardian | Signature | Date