PATIENT PERSONAL INFORMATION

NAME: MR.MRS. MISS. MS. _____
LAST FIRST

DATE OF BIRTH: D____ M_____Y___ AGE _____ MALE ☐ FEMALE ☐

IF CHILD, PARENT/GUARDIAN'S NAME: _____

HOME ADDRESS_____

CITY_____ POSTAL CODE_____ EMAIL _____

PHONE – HOME _____ CELL_____

MEDICAL HISTORY: Alberta Health Care # _____ YES NO

1. Have you ever had a serious illness or are you under the care of a physician now? ☐ ☐
2. Are you presently taking any medications including natural remedies? ☐ ☐
   If yes, please list:
   _____
3. Do you have any allergies to any MEDICATIONS/FOOD PRODUCTS, any unusual reactions? ☐ ☐
   If yes, exp: _____

Penicillin	NSAID's	LOCAL ANAESTHETICS	KELFEX
SULPHONAMIDE (SULFA)	ASPIRIN	ERYTHROMYCIN	PEANUTS
CODEINE	SEDATIVES (tranquilizers)	LATEX	MILK
TETRACYCLINE	BARBITURATE	IODINE	

4. In the last 24 hours have you had a new cough, shortness of breath, fever, chills, diarrhea or other influenza type of symptoms? ☐ ☐
   _____
5. Have you ever had or been recently exposed to any of the following: (Please Circle)

Artificial Heart Valve	Radiation Therapy	Haemophilia	Liver Disease/Jaundice
Artificial Joint(s)_____	Malignant Hyperthermia	Pain of the Jaw Joints	Neck Pains
Heart Murmur	Kidney Trouble	Travelled to Endemic Area	Back Pain
Cold sores/ Canker sores	Rheumatic Fever	Ulcers Stomach trouble	Tuberculosis (TB)
Congenital Heart Lesions	Cancer-Year (_ _ _ _)	Cortisone/ Steroid Meds	Angina / Stroke
Heart disease or Attack	Heart Pacemaker	Chemotherapy	Anaemia / Blood Disorder
Heart Surgery	Diabetes	Epilepsy or Seizures	Hepatitis A/B/C
Bone or muscle Disorder	High Blood Pressure	HIV Positive/AIDS/ARC	Eating Disorder
Leukemia	Blood Transfusion	Prion Disease	Thyroid Disease
STD(syphilis, gonorrhoea)	Blood Thinners	Measles/Chickenpox	HPV

YES NO

5. Do you have any other diseases, conditions or problems not listed above? ☐ ☐
6. Have you ever been advised to take a pre-medication prior to dental procedures? ☐ ☐
7. Do you smoke or chew tobacco products? YES NO If so, how much per day? _____

DENTAL HISTORY

1. What concerns you at present? _____
2. When was you last dental visit?_____ Last cleaning?_____
3. Are your teeth sensitive to: Hot ☐ Cold ☐ Sweets ☐ Biting Pressure ☐

DENTAL OFFICE PERSONAL INFORMATION CONSENT FORM

Name: _____

We are committed to protecting the privacy of our patients' personal information and to utilize 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 described in this form, we collect, use, and disclose information when permitted or required by law.

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

- **To open and update patients' files.**
- **To invoice patients for dental services, to process credit card payments, or 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 examinations or treatment.**

Contact Information is disclosed to third-party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment to 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.
*****Please note that insurance is contract between the plan member, the employer, and the insurer NOT the Dentist. Our administration staff is here to facilitate the paper work on your behalf. Any questions regarding coverage, limitations, and dollar maximums should be directed to your insurer*****

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:

- **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.**
- **To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the 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 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.

_____ _____

Date Print Name Signature