

NEW PATIENT, DENTAL & MEDICAL HISTORY FORM

PERSONAL INFORMATION							
Last Name		First Name		Initial		Preferred Name	
Birthday		Male <input type="checkbox"/>	Female <input type="checkbox"/>	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Child <input type="checkbox"/>	Other <input type="checkbox"/>
Address				City		Postal Code	
Cell Phone				Home Phone			
Bus Phone		Extension		E-Mail			
Family Physician				Telephone			
Emergency Contact Name				Emergency Contact Number			
Occupation							
How did you hear about our office?				Other			
INSURANCE INFORMATION							
Primary Insurance Information							
Name of Insured			Birthday		Employer		
Name of Insurance Co		Policy #		ID #		Div #	
Secondary Insurance Information							
Name of Insured			Birthday		Employer		
Name of Insurance Co		Policy #		ID #		Div #	
DENTAL HISTORY							
How would you rate the condition of your mouth?	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Previous Dentist			
Date of most recent dental exam				Date of most recent x-rays			
What is your immediate concern?							
PLEASE CHECK TO ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS:							
PERSONAL HISTORY							
1. Are you fearful of dental treatment?							<input type="checkbox"/>
2. Have you had an unfavorable dental experience?							<input type="checkbox"/>
3. Have you ever had trouble getting numb or had any reactions to local anesthetic?							<input type="checkbox"/>
4. Did you ever have braces, orthodontic treatment or had your bite adjusted?							<input type="checkbox"/>

GUM AND BONE

5. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	<input type="checkbox"/>
6. Have you ever noticed an unpleasant taste or odor in your mouth?	<input type="checkbox"/>
7. Is there anyone with a history of periodontal disease in your family?	<input type="checkbox"/>
8. Have you ever experienced gum recession?	<input type="checkbox"/>

TOOTH STRUCTURE

9. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	<input type="checkbox"/>
10. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	<input type="checkbox"/>
11. Do you have grooves or notches on your teeth near the gum line?	<input type="checkbox"/>
12. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	<input type="checkbox"/>
13. Do you frequently get food caught between any teeth?	<input type="checkbox"/>

BITE AND JAW JOINT

14. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	<input type="checkbox"/>
15. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	<input type="checkbox"/>
16. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	<input type="checkbox"/>
17. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	<input type="checkbox"/>
18. Are your teeth developing spaces or becoming more loose?	<input type="checkbox"/>
19. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	<input type="checkbox"/>
20. Do you place your tongue between your teeth or close your teeth against your tongue?	<input type="checkbox"/>
21. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	<input type="checkbox"/>
22. Do you clench or grind your teeth together in the daytime or make them sore?	<input type="checkbox"/>
23. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	<input type="checkbox"/>
24. Do you wear or have you ever worn a bite appliance?	<input type="checkbox"/>

SMILE CHARACTERISTICS

25. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	<input type="checkbox"/>
26. Have you ever whitened (bleached) your teeth?	<input type="checkbox"/>
27. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	<input type="checkbox"/>
28. Have you been disappointed with the appearance of previous dental work?	<input type="checkbox"/>

MEDICAL HISTORY

Name of Physician					
Most recent physical examination					
How would you rate your current physical health?		Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	
DO YOU HAVE or HAVE YOU EVER HAD:					
1. Hospitalization for illness or injury?					<input type="checkbox"/>
2. An allergic or bad reaction to any of the following:					<input type="checkbox"/>
Aspirin <input type="checkbox"/>	Codeine <input type="checkbox"/>	Penicillin <input type="checkbox"/>	Erythromycin <input type="checkbox"/>	Sulfa <input type="checkbox"/>	Local Anesthetic <input type="checkbox"/>
Metals (Nickel, Gold, Silver)					
Latex <input type="checkbox"/>	Peroxide <input type="checkbox"/>	Iodine <input type="checkbox"/>	Other <input type="checkbox"/>		
3. Heart problems, or cardiac stent within the last six months?					<input type="checkbox"/>
4. Artificial heart valve, repaired heart defect (PFO)?					<input type="checkbox"/>
5. History of infective Endocarditis?					<input type="checkbox"/>
6. Pacemaker or implantable defibrillator?					<input type="checkbox"/>
7. Orthopedic or soft tissue implant (e.g joint replacement, breast implant)?					<input type="checkbox"/>
8. Heart murmur?					<input type="checkbox"/>
9. Rheumatic or scarlet fever?					<input type="checkbox"/>
10. High blood pressure?					<input type="checkbox"/>
11. Low blood pressure?					<input type="checkbox"/>
12. Stroke (taking blood thinners)?					<input type="checkbox"/>
13. Anemia or other blood disorder?					<input type="checkbox"/>
14. Prolonged bleeding due to slight cu (INR 3.5)?					<input type="checkbox"/>
15. Kidney disease?					<input type="checkbox"/>
16. Liver disease or jaundice?					<input type="checkbox"/>
17. Thyroid, parathyroid disease, or calcium deficiency?					<input type="checkbox"/>
18. Diabetes? (if yes which type)					<input type="checkbox"/>
19. Viral infections and cold sores?					<input type="checkbox"/>

20. Hepatitis? (if yes which type)		<input type="checkbox"/>
21. HIV/AIDS?		<input type="checkbox"/>
22. Radiation therapy, cancer, or chemotherapy?		<input type="checkbox"/>
ARE YOU:		<input type="checkbox"/>
23. Are you presently being treated for any other illness?		<input type="checkbox"/>
24. Are you a smoker?		<input type="checkbox"/>
25. Do you have Glaucoma?		<input type="checkbox"/>
26. Do you have sleep problems? (if yes please elaborate)		<input type="checkbox"/>
27. Are you taking birth control pills?		<input type="checkbox"/>
28. Are you currently pregnant?		<input type="checkbox"/>
29. Currently nursing?		<input type="checkbox"/>
Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)		
List all medications, supplements, and or vitamins taken within the last two years		
Drug Name 1		Purpose
Drug Name 2		Purpose
Drug Name 3		Purpose
Drug Name 4		Purpose
PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.		
Print Patient Name		Date
Signature		

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 described 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, home & work telephone numbers, and email addresses. Contact information is collected and used for the following purposes:

- To open & update patient files.
- To 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 examinations or treatment.
- To send patients informational material about our dental practice.

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 patient's 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 for 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 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 or 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 _____