NEW PATIENT HEALTH HISTORY FORM

Please spend a few minutes completing this New Patient Health History Form, Once complete, click on the Submit Button. This information will then be submitted to your Dental Office securely over the internet. If you wish to keep a copy for yourself, please click on the Print Button.

Title: _____ Given Name:* _____ Pronunciation: _____

*Required fields

Surname:* _____ Preferred Name: _____

Address: _____ Address 2: _____

Province: _____ Postal Code:* _____ Date of Birth:* _____ Gender:* _____

City:* _____ Home #: _____ Occupation: _____ Email: _____

Other Phone: _____ Work #: _____ Contact Method: _____ Employee/School: _____

Are you available for Short Notice Appointments? _____ Emerg. Contact: _____ Phone: _____

If you were referred to us, who referred you? _____ Emerg. Relation: _____

DENTAL INFORMATION

In the following section, please select whichever applies. You answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during you initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions conceming your health.

Do your gums bleed what brushing or flossing? Yes ☐ No ☐

Have you ever had Orthodonic (braces) Treatment? Yes ☐ No ☐

Are your teeth sensitive to cold, hot, sweets, or pressure? Yes ☐ No ☐

Do you feel pain to any of your teeth? Yes ☐ No ☐

Do you have any sores or lumps in your mouth? Yes ☐ No ☐

Have you ever had a head, neck, or jaw injury? Yes ☐ No ☐

Do you have any loose teeth or have they ever shifted? Yes ☐ No ☐

Does food frequently get caught in your teeth? Yes ☐ No ☐

Do you bite your lips or cheeks frequently? Yes ☐ No ☐

Do you have headaches or migraines? Yes ☐ No ☐

Have you had any difficult extractions in the past? Yes ☐ No ☐

Ever worn a bite plate or other appliance? Yes ☐ No ☐

Have you ever had difficulty opening or closing your jaw? Yes ☐ No ☐

Have you had any pain in your jaw area? Yes ☐ No ☐

Have you ever had Periodontal Treatment (gums)? Yes ☐ No ☐

If you have a current dental problem, please describe:

Please give a brief discription of your oral hygiene habits:

Do you have any other concerns about having dental treatment? If so, please explain Yes ☐ No ☐

Please enter your previous dentist's name and location:

Do you ever feel nervous about visiting the dentist? If so, please explain Yes ☐ No ☐

Are you happy with the appearance of your teeth? If not, please explain Yes ☐ No ☐

Date of your last dental x-ray

Date of your last teeth cleaning

Date of your last dental exam

What can we do to make you smile? Check all that apply and we'll get back to you with more information about your inquiry:

☐ Veneers ☐ Oral Concious Sedation ☐ Neuromuscular Dentistry ☐ Instant Orthodontics ☐ Broken/Cracked Teeth ☐ Invisalign Teeth Straightening

☐ Gummy Smile ☐ Total Smile Makeovers ☐ Replace Missing Teeth ☐ Cosmetic Dentures ☐ Dental Implants ☐ One Hour In-Office Whitening

☐ White Fillings ☐ Replace Metal Fillings ☐ Correct Misaligned Teeth ☐ Sleep Apnea/Snoring ☐ Eliminate Gaps ☐ Rejuvinate Worn/Stained Teeth

MEDICAL INFORMATION

Dental professionals primarly treat the area in and around your mouth, but since your mouth is part of your body, any medication you are taking and your health history have a important relationship with your Dental Treatment. Please answer the following questions.

Are you currently seeing a Family Physician? If so, please enter their name, phone number, and the date your of last visit. Yes ☐ No ☐

Have you recently (in the last two years) been hospitalized or had a major operation? Please explain. Yes ☐ No ☐

Have you ever had a serious head or neck injury? If so, please explain. Yes ☐ No ☐

Date of your last physical exam:

Are you or could you be pregnant? Yes ☐ No ☐ If yes, what is the expected delivery date? _____ Taking birth control pills? Yes ☐ No ☐

Please go over the following section and indicate which of the following you have or have had. If you need to add any further information, please enter it at the end.

AIDS/HIV Positive	Yes ☐ No ☐	Chest Pains	Yes ☐ No ☐	Hemophilia	Yes ☐ No ☐
Alzheimer's Disease	Yes ☐ No ☐	Circulation Problems	Yes ☐ No ☐	Hepatitis A	Yes ☐ No ☐
Anaphylaxis	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Hepatitis B or C	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐
Arthritis/Gout	Yes ☐ No ☐	Epilepsy/Seizures	Yes ☐ No ☐	Kidney Problems	Yes ☐ No ☐
Artificial Heart Valve	Yes ☐ No ☐	Fainting	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐
Artifical Joint	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐	Lung Disease	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Head or Neck injuries	Yes ☐ No ☐	Mental/Nervous Disorder	Yes ☐ No ☐
Blood Disease	Yes ☐ No ☐	Heart Attack/Failure	Yes ☐ No ☐	Organ/Medical Transplant	Yes ☐ No ☐
Bruise Easily	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐	Sickle Cell Disease	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Heart Pacemaker	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Chemotherapy	Yes ☐ No ☐	Heart Surgery	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐

Please enter details or any further information.

Please list any prescription or non-prescripton medicine you are currently taking or have recently taken.

Are you allergic to have you had a reaction to any of the following items?

Barbiturates, Sedatives or Sleeping Pills	Yes ☐ No ☐
Antibiotics	Yes ☐ No ☐
Aspirin	Yes ☐ No ☐
Codeine	Yes ☐ No ☐
Darvon	Yes ☐ No ☐
Local Anaesthetic	Yes ☐ No ☐
Nitrous Oxide	Yes ☐ No ☐

Other

Do you use any form of tobacco or wear a nicotine patch?	Yes ☐ No ☐
Are you dependent on alcohol or drugs	Yes ☐ No ☐
If so, have you received treatment?	Yes ☐ No ☐
Have you ever tested HIV positive?	Yes ☐ No ☐

If you have ever been advised against taking any type of medication, please list them below.

If you have any allergic conditions please list them below. This can include asthma, hay fever, food allergies, and metal or latex allergies.

Do you bruise easily or bleed severely when you are cut?	Yes ☐ No ☐
Do you have severe earaches, ear or throat infections, or headaches?	Yes ☐ No ☐
Do you wear eyeglasses or contact lenses?	Yes ☐ No ☐

CHILDREN ONLY

Please list any medical conditions or illnesses the child has recently had.This can include measles, strep throat, tonsillitis

INSURANCE INFORMATION

Primary Insurance

Subscriber Name: _____ Relationship: _____

Insurance Name: _____

Policy Number: _____ Policy Description: _____

Subscriber ID #: _____ Division Number: _____

Secondary Insurance

Subscriber Name: _____ Relationship: _____

Insurance Name: _____

Policy Number: _____ Policy Description: _____

Subscriber ID #: _____ Division Number: _____

PERSONAL INFORMATION PATIENT 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, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses. (Collectively referred to us "Contact Information"). Contact Information is collected and used for the following purposes:

- To open and 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 the reminders to the patients concerning the need for further dental examination 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 is collected for payment processing purposes. it is not shared with third parties without your consent, unless permitted by law for outstanding bill collection purposes.

We collect information from our patients about their health history, their family health history, physical condition and dental treatments. (Collectively referred to us "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 patient's behalf.
- With the consent of the patient, to other dentists and dental specialists, or to other health care professionals.
- 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 step 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.

Name:	Date:	Signature: