FOREST HEIGHTS FAMILY DENTAL
MORE REASONS TO SMILE

PERSONAL INFORMATION (PLEASE PRINT)

Date: _____

Name: _____ Preferred Name: _____

Date of Birth: _____ Height _____ Weight _____

Address: _____ Postal Code: _____

Phone – Home: _____ Cell: _____ Work: _____

Email: _____

How did you hear about us? _____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor or in the hospital during the past 2 years?
   YES or NO If yes, please specify: _____
2. Are you allergic to (itching, rash, swelling of hands, feet, eyes or made sick by) penicillin, aspirin, codeine or any drugs, latex/rubber products?
   YES or NO If yes, please specify: _____
3. Have you ever had any excessive bleeding requiring special treatment?
   YES or NO If yes, please specify: _____
4. Has your medical doctor ever said you have cancer or a tumour? YES or NO _____
5. Do you have pain in chest, or shortness of breath: walking up or down stairs?
   YES or NO If yes, please specify: _____
6. Do your ankles swell during the day? YES or NO _____
7. Do you ever wake up from sleep short of breath? YES or NO _____
8. Are you on a special diet? YES or NO _____
9. Ladies: Are you pregnant? YES or NO Are you practicing birth control? YES or NO
   Breast feeding? YES or NO _____
10. Are you presently taking any kind of medications?
    YES or NO If yes, please specify: _____
    _____
    _____
11. Any adverse reactions? YES or NO _____

12. Do we have permission to request a list of current medications on your behalf from your pharmacist? If yes, please provide Pharmacy name: _____
Phone: _____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

Aids – Allergies – Anemia – Angina – Pectoris – Arthritis – Artificial heart valve – Artificial joint – Asthma – Blood transfusion – Bruise easily – Chemotherapy – Cold Sores – Congenital Heart – Lesions – Cortisone Medicine – Cough – Diabetes – Drug Addiction – Emphysema – Epilepsy or Seizure – Fainting or Dizzy Spells – Genital Herpes – Glaucoma – Hay Fever – Heart Disease or Attack or Surgery – Heart Failure – Heart Murmur – Hemophilia – Hepatitis A,B,C (infectious) (serum) – High Blood Pressure – HIV – Kidney Trouble – Liver Disease – Nervousness – Pacemaker – Pain in Jaw or Joints – Polio Psychiatric Treatment – Rheumatic Fever – Rheumatism – Scarlet Fever – Sickle Cell Disease – Sinus Trouble Stroke – Smoker (Cigarette/Tobacco) – Tuberculosis (TB) – Thyroid Disease – Ulcers – Venereal Disease – Yellow Jaundice

DENTAL HISTORY

1. How frequently do you see your Dentist? _____
   Last Dental Visit _____
2. Have you ever had local anaesthetic? YES or NO _____
   Any Complication? YES or NO _____
3. Do your gums feel swollen or tender? YES or NO _____
4. Do you catch food between your teeth? YES or NO _____
5. Are you aware of any loose teeth? YES or NO _____
6. Does your jaw crack, pop, or grate when you open wide? YES or NO _____
7. Do you grind or clench your teeth? YES or NO _____
8. Are any of your teeth sensitive to Cold _____ Heat _____ Other _____
9. Do you gums bleed when you Brush _____ Floss _____ Other _____

PATIENT/GUARDIAN CERTIFICATION AND APPROVAL

To the best of my knowledge, all the preceding answers are true and correct. If I have any change to my health, my insurance or my medications I will inform my dentist at the next appointment without fail. I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for fees associated with these procedures.

I understand it is the office policy that 48 hours notice is required to make changes to my appointment. I am responsible to pay a fee if I cancel my appointment with short notice or do not attend my appointment without a valid reason (Each case will be determined individually)

_____ _____
Print Name Patient's and/or Guardian's Signature

DENTAL OFFICE PERSONAL INFORMATION CONSENT FORM

PERSONAL INFORMATION AND PROTECTION ACT

We are committed to protecting the privacy of our patient's 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 numbers, work telephone numbers and email addresses. (Collectively referred to as "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 payment, 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 dental materials
- To follow up with treatment and/or customer services

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".) Patient's medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patient's medical information is disclosed for the following purposes:

- To third party health benefit providers and insurance companies where the patient has submitted 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
- 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 dentists or 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 healthcare 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 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.

Patient/Guardian Name: _____ Signature:_____ Date: _____