FULL MEDICAL HISTORY

PERSONAL INFORMATION

☐ Male ☐ Female

Name: _____ _____
Last First

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

HOW WOULD YOU LIKE TO CONFIRM YOUR APPOINTMENTS? EMAIL CELL/TEXT HOME **WE USE AN AUTOMATED SYSTEM FOR COMMUNICATIONS**

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

Date of Birth: _____ **Emergency Contact (Ph#/Name):** _____
Day Month Year

Employer: _____ **Email:** _____

How did you hear about our office? ☐ **Website** ☐ **YellowPages** ☐ **Family/Friend** ☐ **Co-Worker** ☐ **Location**
☐ **Other/Whom may we thank?** _____

MEDICAL HISTORY

Family Physician/Doctor Name: Dr. _____ **Phone #:** _____

Have you ever had the following diseases or medical problems? **PLEASE CIRCLE (YES/NO)**

Y / N ☐ Heart Attack ☐ Stroke ☐ Heart Disease
Y / N ☐ Artificial Valves ☐ Stents/Prostheses
Y / N ☐ Heart Murmur ☐ Rheumatic Fever
Y / N ☐ Heart Surgery ☐ Pacemaker
Y / N ☐ Congenital Heart Defect ☐ Mitral Valve Prolapse
Y / N Sinus Problems: _____
Y / N ☐ High Blood Pressure ☐ Low Blood Pressure
Y / N Lung: ☐ TB ☐ Emphysema ☐ Asthma ☐ COPD
Y / N ☐ Kidney disease ☐ Thyroid_____
Y / N Diabetes Type: _____
Y / N ☐ Liver ☐ Hepatitis A or B or C
Y / N ☐ Knee ☐ Hip ☐ Ankle ☐ Pins ☐ Plates
Y / N ☐ Anxiety ☐ Depression ☐ Psychiatric disorder
Y / N ☐ Epilepsy ☐ Seizures ☐ Fainting Spells

Y / N ☐ Ulcers ☐ Colitis ☐ Crohns
Y / N ☐ Cancer ☐ Chemotherapy-Date: _____
Y / N ☐ Anemia ☐ Radiation Treatment
Y / N Sexually Transmitted Diseases_____
Y / N ☐ HIV Positive ☐ AIDS ☐ Blood Transfusion
Y / N Cold Sores *re-schedule appointments when have
Y / N ☐ Hemophilia ☐ Abnormal Bleeding
Y / N ☐ Severe headaches ☐ Frequent Headaches
Y / N ☐ Drug Abuse ☐ Alcohol Abuse ☐ Past ☐ Present
Y / N Chewing Tobacco: ☐ Past ☐ Present
Y / N ☐ Smoker ☐ Vaper ☐ Past ☐ Present
Y / N ☐ Prescription Marijuana ☐ Cannabis Oil
Y / N Are you taking any oral contraceptives
Y / N Are you pregnant?_____Weeks

Y / N Any Other Medical Concerns we should know about? _____
Y / N ☐ Jaw Joint Pain ☐ Jaw Soreness ☐ Jaw click/crack/pop ?_____
Y / N Do you presently have: ☐ Current Persistent Cough ☐ Chronic Diarrhea ☐ Undiagnosed Skin Rash
Y / N Have you traveled outside of Canada in last 12 months? Date/Location:_____
Y / N Any medical conditions or surgery that requires you to be pre-medicated prior to dental treatment?
Y / N Are you nervous about or have you had a negative dental experience?_____
Y / N Are you happy with your smile?_____

Please list any medications/herbal supplements or over the counter medications you are currently taking:

_____

ALLERGIES: _____

☐ Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Erythromycin ☐ Food ☐ Latex ☐ Anesthetics ☐ Nuts/Dairy ☐ Other

Signing this document I also acknowledge all documents will be digitally converted and archived as such only. All my documents active or achived in digital format I recognize them as valid legal documents."

Patient/Parent/Guardian Signature: _____ **Date:** _____/ 2018

ACKNOWLEDGEMENT OF CANCELATION POLICY

PATIENTS ARE RESPONSIBLE FOR PROVIDING 48 HOURS NOTICE FOR APPOINTMENT CANCELLATIONS. IF YOU CANCEL OR NO SHOW, WE LOSE TWO PATIENTS, YOU AND THE PERSON WHO WOULD HAVE BEEN TREATED IN THAT TIME SLOT. I ACKNOWLEDGE THAT WITH OUT PROPER NOTICE I WILL BE CHARGED A $100.00 FEE THAT IS UNCOLLECTIBLE BY A THIRD PARTY AND IS MY PERSONAL RESPONSIBILITY TO PAY. _____ INITIALS

INSURANCE INFORMATION

#1 POLICY HOLDER_____Birthdate_____/_____/_____
DAY MONTH YEAR

Employer_____

Insurance Company_____Policy #_____Div/Class_____ID#_____

Basic Services_____% Maximum $_____Major Services_____% Maximum $_____

Recall Frequency_____months / Root Planning/Scaling_____units

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#2 POLICY HOLDER_____Birthdate_____/_____/_____
DAY MONTH YEAR

Employer_____

Insurance Company_____Policy #_____Div/Class_____ID#_____

Basic Services_____% Maximum $_____Major Services_____% Maximum $_____

Recall Frequency_____months / Root Planing/Scaling_____units

- As a special service to our patients we are able to bill your insurance company directly for your dental treatment. If you have ANY questions regarding your insurance we recommend that you contact your insurance company directly. It is important that you be familiar with your dental plan BEFORE treatment in order to eliminate any disappointment with coverage and reimbursement.
- Your benefit coverage is a contract between yourself, your employer and the insurance company. Personal plan information is considered “confidential medical information” and such it will not be released to us as your dental provider.
- NOTE:Tthe Alberta Dental Association provided a suggested 2018 fee schedule. Our fees now reflect our regional cost of supplies, equipment, education and services. It is likely that there will be a difference between our fees and the fees paid by your dental plan.
- I have read and fully understand the above conditions and that as a courtesy my insurance plan will be billed. I will pay the patient portion you estimate at each visit, BUT agree that I am ultimately responsible for the payment of this office’s full dental fees. All unpaid balances over 45 days are automatically billed directly to me.

I ,_____ give C U Smile Dental Care the authorization to charge the balance of my account to my credit card # _____expiry _____/_____
(American Express/Visa/ Mastercard) not to exceed the amount of $50.00 or $100.00 in the event that my insurance company does not pay the full balance left on my account. The amount will automatically be charged to the above number for the sole purpose of dental treatment provided and a receipt will be mailed.

If I do not have dental insurance coverage, I am aware that I am fully responsible for all charges incurred on the day of treatment.

Patient/Parent/Guardian Signature _____ Date _____/2018

OVER →

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 address, work address, home telephones numbers, work phone 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
- 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 examination or treatment
- To send patients information material about our dental materials
- 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.

During treatment, photographs are taken to document certain intra-operative conditions.

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 re-imbursement 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 dentist 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 specialist if the patient, 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 considering selling all or part of our dental practice, qualified potential purchasers may be granted access a 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 staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal information and any dependents as set out above.

_____/2018	_____	_____
DATE	PRINT NAME	PATIENT/ GUARDIAN SIGNATURE