PATIENT INFORMATION

Patient's Name_____Date_____

Address_____City_____Prov._____Postal Code_____

Home Phone_____Cell_____Work Phone_____Ext._____

E-mail_____ How do you identify your gender (Select all that apply) □ Male □ Female □ Transgender □ I do not identify as a gender □ Other _____

Date of Birth_____Physician_____

AHC# _____Pharmacy _____

Occupation_____Employer_____

Emergency Contact _____ Phone #_____

Preferred method of communication □ Home Phone □ Cell Phone □ Work Phone □ Text □ Email

Personal Information Disclosure Consent

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 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 payments, or to collect unpaid accounts.
- To send reminders to 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 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.

Patients' Medical Information is disclosed:

- To third-party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement for 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 another 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 healthcare professionals such as physicians if the patient, with their consent, has been referred by us to the other healthcare 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 our records and interview our staff as part of it's regulatory activities in the public interest.

I consent for collection, use and disclosure of my personal information as set out above. _____

Informed Treatment Consent

It is the intent of this office that all treatment be done with what we call "Informed Consent". This means that the patient or guardian or parent of a patient is, after the diagnostic part of an examination, informed as to the alternatives of treatment and their implications, the financial cost of any required or desired treatment, and the known potential complications that can arise from treatment.

We do our best to review these areas with the responsible party, but if there are any areas which are not clear about the treatment planned, it is important, for the responsible party for the patient's care, to review it with the Doctor.

I, as the responsible party for the care of the below named patient, do here-by give permission to the staff and Doctor's in the office of Westlock Dental Centre, to perform required and/or desired dental procedures on the below mentioned patient, on the basis that "Informed Consent" is obtained.

_____ _____ _____

Signature Patient/Parent/Guardian | Printed Patient Name | Date

MEDICAL HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dentistry treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs? YES NO
   Please list:
   1._____ 2._____ 3. _____
   4._____ 5._____ 6. _____

5. Are you allergic to any of the following? (Please circle.) ANTIBIOTICS - Penicillin, Keflex, Dalacin, Sulfa, or other antibiotics, ASPIRIN, VALIUM, CODEINE, NARCOTICS, LOCAL ANAESTHETIC (freezing), any other medicine: _____ YES NO
6. Do you have any of the following? Asthma, Hay Fever, Food Allergies, metal or latex Allergies, Skin Rashes,Hives, or any other allergic conditions?_____ YES NO
7. Have you been advised by your medical Doctor or Dentist to take antibiotics prior to dental treatment? YES NO
8. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? ..... YES NO
9. Have you been under the care of a medical doctor or hospitalized within the last 2 years? ..... YES NO
   Reason for?_____
10. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infection or sinus infections?.. YES NO
11. Have you ever had any injury or surgery to your face, jaws or neck, or head? ..... YES NO
12. Do you experience pain in jaw joints? ..... YES NO
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
16. Are you on a special diet? ..... YES NO
17. Are you alcohol, drug or tobacco dependent? ..... YES NO
18. Do you have artificial joints (hip, knee)? ..... YES NO
    Where?_____ Date of placement? _____
19. Have you tested HIV positive, or come in contact with the AIDS virus? ..... YES NO
20. Circle which of the following you presently have or ever had:

Anemia	Epilepsy or Seizures	Liver Disease
Angina Pectoris	Fainting or Dizzy Spells	Lung Disease
Arthritis/Rheumatism	Glandular Disorders	Malignant Hyperthermia
Artificial Heart Valve	Glaucoma	Mitral Valve Prolapse
Blood Disorders	Heart Disease or Attack	Organ Transplant/Medical Implant
Blood Transfusion	Heart Murmur	Psychiatric Treatment
Bronchitis	Heart Pacemaker	Rheumatic / Scarlet Fever
Cancer	Heart Rhythm Disorder	Sickle Cell Disease
Cholesterol (high or low)	Heart Surgery	Sinus Trouble
Chemotherapy/Radiation	Hemophilia	Stomach / Intestinal Problems
Circulation Problems	Hepatitis A	Stroke
Cold Sores	Hepatitis B	Thyroid Disease
Congenital Heart Lesions	Hepatitis C	Tuberculosis
Cortisone/Steroids	High/Low Blood Pressure	Ulcers
Diabetes	Hodgkin Disease	Venereal disease
Diet controlled?	Hyper (Hypo) Glycemia	Syphilis
Insulin controlled?	Hypertension	Gonorrhea
Eating Disorders	Jaundice	Other_____
Emphysema	Kidney Disease	

21. WOMEN ONLY: Are you pregnant or suspect you may be? ..... YES NO
    If yes, what is the expected delivery date?_____ Are you taking any birth control pills?_____
22. Do you wish to speak to the Dentist privately about any above information? ..... YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the Dentist at the next appointment.

Date	*Patient, Parent or Guardian Signature*	*Doctor's Signature*