PATIENT REGISTRATION FORM

Date: _____

Office Use Only
ASA 1 2 3 4 5 E

PATIENT NAME _____
(Last) (First) (Middle)

Birthdate (yy/mm/dd)	Age	☐MALE ☐FEMALE

Allergies

Alert

Health Care Number _____ Health Care Province _____

Previous Dentist _____

Referred by

Family Physician _____

PATIENT CONTACT INFORMATION

Home Address _____ Occupation _____
City _____ Employer _____
Province _____ Work Address _____
Postal Code _____ City _____
Home Phone _____ Province _____
Cell Phone _____ Postal Code _____
Email Address _____ Work Phone _____
If a patient is a minor, provide parent or legal guardian's name _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name _____ Home Phone _____
Home Address _____ Cell Phone _____
City _____ Work Phone _____
Province _____ Employer _____
Postal Code _____ Relationship to Patient _____

Is this a Workman's Compensation Claim? ☐Yes ☐No If yes, provide CLAIM # and SIN # _____

If you are covered by Social Assistance, please present your card to reception and provide I.D. # _____

If you are covered by Indian Affairs provide I.D. # _____ Band Name _____

DENTAL INSURANCE	FIRST POLICY	SECOND POLICY	THIRD POLICY
Name of Subscriber (Policy Holder)			
Subscriber's Birthdate (yyyy/mm/dd)			
Employer			
Name of Insurance Plan/Company			
Group Plan/Policy #			
Subscriber's Certificate/I.D. #			
Division/Section #			
Relationship to Patient			
Home Phone			
Work Phone			
Cell Phone			
Street address if different from above			
City			
Province			
Postal Code			

To the best of my knowledge, I certify that the above information is correct.

_____
Patient/Parent/Legal Guardian Signature

CONFIDENTIAL MEDICAL HISTORY

ALLERGIES	ALERT	TMJ	ASA
			1 2 3 4 5 E

For office use only

PATIENT'S LAST NAME		GIVEN NAMES			
Birth Date YYYY/MM/DD	Age	☐ Male ☐ Female	Height	Weight	List any Medication Allergies (rash, swelling, hives)

Reason for referral to our office? _____

How long has it been a problem? _____ Are you currently in pain? _____

List all childhood diseases: _____

List any past hospitalizations or surgical procedures:

List any current medications, herbal products, or non-prescription drugs (drug name, dose, frequency)

Do You Have a History of:	YES	NO		YES	NO		YES	NO
Heart Attack			Chronic Cough			Diabetes		
Heart Congestion/Failure			Tuberculosis			High Blood Pressure		
Heart Surgery			Other Lung Disease			Kidney Problems		
Heart Murmur			Sleep Apnea			Urinary Problems		
Chest Pain			Jaundice			Stomach Ulcers		
Pace Maker			Hepatitis			Heartburn/Acid Reflux		
Artificial Heart Valve			Liver Disease			Thyroid Disease		
Congenital Heart Disease			Alcoholism			Epilepsy or Seizures		
Swollen Ankles			Psychiatric Care			Concussion		
Rheumatic or Scarlet Fever			Anxiety Disorders			Cancer		
Fainting or Dizziness			Recent Weight Change			Radiation Therapy		
Stroke			Artificial Joint Replacement			Chemotherapy		
Blood Clots			Muscle Disorder			Cortisone/Steroid Use		
Hemophilia			Arthritis			Glaucoma		
Bruising Easily			Blood Transfusion			Cold Sores		
Sickle Cell Disease			AIDS/HIV			Genital Herpes		
Anemia			Venereal Disease			Use of Street Drugs		

Please provide details to all the following "yes" questions	YES	NO	Notes
Have you been under the care of a physician in the past 5 years?			
Are you disabled in any way?			
Do you have a personal or family history of porphyria?			
Are you on any special diet? Is it on the advice of a physician?			
For women, are you or could you be pregnant?			
Have you had any heart problems in the past?			
Are you taking blood thinners or aspirin? If so, why?			
When you walk up the stairs or walk several blocks do you get short of breath, chest pain, or excessively tired?			
Is there a personal or family history of allergies or unfavourable reaction to local or general anesthetics?			
Do you have a history of asthma, bronchitis or emphysema? If so, record date of last attack and indicate if you were ever hospitalized.			
Do you smoke? If so, how much and for how many years? If you quit, when did you quit?			
Do you have a personal or family history of malignant hyperthermia? Or of cholinesterase deficiency?			
Do you suffer from osteoporosis?			
Do you take a bisphosphonate (Fosamax, Didrocal, Actonel) for osteoporosis?			
Do you have any jaw joint (TMJ) problems, or jaw muscle problems?			
Is there anything special about your medical history or physical condition that you feel we should know about?			

To the best of my knowledge, I certify that the above information is correct.

Name of Person Providing Information _____ Signature _____ Date _____

Patient Privacy Policy

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible, ethical, 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 as "Contact Information"). Contact Information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients, and/or legal guardians, or persons financially responsible for patient accounts, for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party dental benefit providers, insurance companies, and government agencies.
- To send patients informational material about our dental practice.
- To send reminders to patients concerning the need for further follow-up, treatment, or dental examination.

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 if the patient 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 from whoever has been written as financially responsible for the account.

We collect information from our patients about their health history, their family 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 all third-party benefit providers, insurance companies, and government agencies 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.
- 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.
- To laboratories, hospitals, radiology centres, or other healthcare related facilities, when required to gather and share information to facilitate timely and appropriate treatment.
- For educational purposes, limited to include non-identifiable information, in formats such as videos, pictures and slides.
- When a student and/or other health care practitioner may observe for educational purposes.

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. This agency may inspect our records and interview our staff as part of regulatory activities in the public interest.

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

_____ Date

_____ Patient / Parent / Legal Guardian Signature