DOWSETT
DENTAL HEALTH

Patient Information

Patient Name: ______________________________________ Gender:_____ Date: ____________
Last, First MI (Preferred Name) M/F

Birth Date:____________ Family Status:__________ Email Address:______________________
(dd/mm/yyyy) Married/Single/Child

Phone (Home): ______________ (Cell):______________ (Work): ______________ ext.________

Address: ____
Street Apartment #

____
City Province Postal Code

Emergency Contact Information

Whom may we contact in case of emergency?

1. Name______________________ Phone.______________ Relationship______________

2. Name______________________ Phone.______________ Relationship______________

Referral Information

How did you hear about us? ☐ Another patient ☐ Blue Cross ☐ UofC/SAIT/MRC ☐ Dental Office ☐ Denturist

☐ Yellow Pages ☐ Internet ☐ Advertisement ☐ Other ______________________________

Name of person or office we may thank for referring you to our practice: ______________________

Insurance Information

Primary

Name of Insured: ______________________________________ Is insured a patient?☐Yes ☐No
Last First MI

Insured's Birth Date: ______________ Insured's Address: ______________________________
Street City Province Postal Code

Insured's Employer Name: ______________________________________

Patient's relationship to insured:☐Self ☐Spouse ☐Child ☐Common Law☐Other ______________

Insurance Plan Name:______________Group#______________Cert/ID#______________

Secondary

Name of Insured: ______________________________________ Is insured a patient?☐Yes ☐No
Last First MI

Insured's Birth Date: ______________ Insured's Address: ______________________________
Street City Province Postal Code

Insured's Employer Name: ______________________________________

Patient's relationship to insured:☐Self ☐ Spouse ☐Child ☐Common Law ☐Other ______________

Insurance Plan Name:______________Group#______________Cert/ID#______________

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PATIENT MEDICAL HISTORY RECORD

NAME:______________________ AGE:______________________

PHYSICIAN:____________________ PHYSICIAN Ph.___________ MEDICAL ALERT:____________

The following information is required to help us provide you with the best possible dental care. All information is protected by doctor-patient confidentiality. The dentist will review the responses and explain any further questions you may have. Please fill in the entire form.

1. When was your last medical checkup with your physician? ____________________
2. Are you being treated for any medical condition at present or have you been within the past 2 years? If so, please explain? YES NO UNSURE
3. Have there been any changes in your general health in the past year? If yes, please explain. YES NO UNSURE
4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.____ YES NO UNSURE
5. Do you have any allergies? E.g. medications, latex/rubber products YES NO UNSURE
6. Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain____ YES NO UNSURE
7. Do you have or have you ever had any heart or blood pressure problems? YES NO UNSURE
8. Do you have or have you ever had heart murmur, artificial heart valve, endocarditis, Congenital heart defect or other heart abnormalities? YES NO UNSURE
9. Do you have a prosthetic or artificial joint? If yes, when was it placed? YES NO UNSURE
10. Have you ever been advised by your medical doctor to take antibiotics **before** dental treatment? YES NO UNSURE
11. Do you have any conditions or therapies that could affect your immune system? e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? YES NO UNSURE
12. Have you ever had hepatitis, jaundice or liver disease? YES NO UNSURE
13. Do you have a bleeding problem or bleeding disorder? YES NO UNSURE
14. Have you ever been hospitalized for any illness or operations? If yes, please explain. YES NO UNSURE
15. Do you have **OR** have you ever had any or the following? Please Circle.

Chest pain, angina	**Shortness of breath**	**Pacemaker**	**Seizures(epilepsy)**	**Lung disease**
Heart attack	**Prosthetic Heart Valve**	**Diabetes**	**Kidney Disease**	**Stroke**
Tuberculosis	**Steroid Therapy**	**Stomach Ulcers**	**Arthritis**	**Thyroid Disease**
Cancer	**Drug/alcohol dependency**	**Asthma**	**Osteoporosis**	

16. Are there conditions/diseases not listed above that you have or have had? If so, please explain? YES NO UNSURE
17. Are there any disease or medical problems that run in your family? e.g. diabetes, cancer, or heart disease. Please list ______________________ YES NO UNSURE
18. Do you smoke or chew tobacco products? If so, how much? YES NO UNSURE
19. Are you nervous during dental treatment? YES NO UNSURE
20. **For women only:** Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?______________________ YES NO UNSURE

To the best of my knowledge, the above information is true and correct. If I ever have any change in my health, I will inform the doctor's at the next appointment.

______________________________ ______________________________

PATIENTSIGNATURE (GUARDIAN IF UNDER 18) **DATE (dd/mm/yy)**

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PATIENT DENTAL HISTORY

NAME: ______________________________

What dental condition concerns you at present? ______________________________

Date of last visit to a dental office: ______________________________

What was it for? Check-up ☐ Filling ☐ Toothache ☐ Cleaning ☐ Other ☐

Have you ever had a bad experience during dental treatment? Yes ☐ No ☐

If yes, was there: Fainting ☐ Bleeding ☐ Reaction to anesthetic ☐ Other ☐

Have you ever had any of the following treatments? (please check)

Root Canal	☐	Braces (orthodontics)	☐	Periodontics (gums)	☐
Extractions	☐	Crowns	☐	Filling	☐
Dental Hygiene	☐	Dental Implants	☐	Bridge	☐

Are you satisfied with your previous dental treatment? Yes ☐ No ☐

If not, what would have made it easier: ______________________________

Were you satisfied with your previous dental office? Yes ☐ No ☐

If there is anything we can do to make your experience as pleasant as possible please explain: ______________________________

Are you aware of any swelling, soreness, rough areas, ulcers, erosions or colour changes in your mouth? (please circle all that apply) Yes ☐ No ☐

Have you ever noticed: bleeding gums? ☐ receding gums? ☐ sore gums? ☐

When did you last have your teeth cleaned? ______________________________

How often do you brush? ______________________________

How often do you floss? ______________________________

Are your teeth sensitive to: cold? ☐ heat? ☐ sweet? ☐ chewing? ☐ brushing? ☐

Does food catch between your teeth? Yes ☐ No ☐

Are there any new spaces between any teeth? Yes ☐ No ☐

Do you like the way your teeth look? Yes ☐ No ☐

Do you (or the patient, if child) have any habits that involve your mouth? (please check all that apply): Yes ☐ No ☐

Grinding	☐	cheek biting	☐	lip biting	☐
mouth breathing	☐	tongue thrusting	☐	thumb sucking	☐
holding pins	☐	biting nails	☐	clenching	☐
going to bed with bottle	☐				

Do you experience pain or difficulty when you: yawn? ☐ chew? ☐ speak? ☐ swallow? ☐

Do you experience any of the following? (please check all that apply):

Sore jaw muscles	☐	Frequent headaches	☐	Lock/Pop Jaw	☐
Uncomfortable / Unusual bite	☐	Clicking or popping sounds in jaw	☐		

Have you had a recent injury to your head, neck or jaw? Yes ☐ No ☐

Have you previously been treated for a jaw joint problem? Yes ☐ No ☐

Do you wear a splint or Nighttime grinding appliance? Yes ☐ No ☐

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Dental Office 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 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 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 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 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.

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 its regulatory activities in the public interest.

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

PATIENT NAME	_SIGNATURE (Parent/Guardian if Under 18)_	_DATE_