SOUTHWOOD DENTAL

## Medical and Dental History

**Patient Name (Last, First)** ________________________________ **Name of Parent/Guardian**____________________

**Date of Birth (D/M/Y)** ___________________________ **Occupation** ______________________________________

**Home Address** ______________________________________________________ **City/Province** ______________

**Postal Code** ________________**Home Phone** _____________________ **Cell Phone**___________________________

**Work Phone** _______________ **Email** __________________________________________

**Preferred Method of Contact:** ☐ **Home** ☐ **Cell** ☐ **Work** ☐ **Email**

**How did you hear about us? (Please check one):** Google Facebook Walk/Drive By Flyer Friend/Family

**Whom may we thank for your referral?** Name(s):_____________________________

Are you presently under the care of a physician? **Yes / No** If yes, name:____________________________________________

Are you taking any drugs or medications at this time? If yes, please list with dosages

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Are you allergic to any of the following (please check if yes):

☐ Penicillin ☐ Sulfa ☐ Latex ☐ Other _________________________

☐ Codeine ☐ Aspirin ☐ Local Anesthetic _____________________________

Have you ever been warned against using any other medications: **Yes / No** Which? ____________________

Have you had any serious illness or operation / or have you ever been hospitalized? **Yes / No**Which? __________________

Have you been told you require premedication prior to dental treatment **Yes / No** If yes, why? _________________________

Do you bruise easily or have prolonged bleeding? **Yes / No** Explain ______________________________________

Do you take any blood thinners or anticoagulants? **Yes/ No** If yes, please list _______________________________________

Do you smoke? **Yes/ No** How much per day? _________________________________________________

Do you ever faint, have shortness of breath or chest pain? **Yes / No**Which? ____________________________________

-WOMEN- Are you pregnant? **Yes / No**How many weeks? _________ Are you currently breastfeeding? **Yes / No**

Do you have or have you ever had the following?

☐ Heart disease/attack
☐ Angina pectoris
☐ Heartpacemaker/surgery
☐ Artificial heart valve
☐ Heart murmur
☐ Artificial joint (hip/knee)
☐ Congenital heart lesions
☐ Rheumatic/Scarlet fever
☐ Mitral valve prolapse
☐ High/Low blood pressure
☐ Diabetes
☐ Kidney disease
☐ Emphysema
☐ Epilepsy
☐ Glandular disorders
☐ Glaucoma
☐ Asthma
☐ Blood disorders
☐ Radiation/Chemotherapy
☐ Cancer
☐ Anemia
☐ Bronchitis
☐ Stroke
☐ Thyroid disease
☐ Mental/nervous disorder
☐ Liver disease
☐ Arthritis
☐ Leukemia
☐ Lung Disease
☐ Tuberculosis
☐ Venereal disease A.I.D.S./H.I.V.
☐ Hepatitis A/B/C
☐ Herpes
☐ Other_____________
☐ Migraines

Do you have any disease or problem not listed above you think I should know about? **Yes / No**

If yes please list ___________________________________________________________________________

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**Dental History**

What is the reason for today's visit? ________________________________________________

When was your last dental visit? ______________________ Last dental x-rays? ______________________

Previous Dentist? ______________________________________ Number: _______________________________

Have you ever had any problems with previous dental treatment? Please specify: ________________________________

Is there anything else that you feel we should know about your dental history? ________________________________

**Emergency contact** ________________________________________________ **Phone #**____________________________________

**Treatment Consent**

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed or advisable, including the use of local anaesthetic as indicated. I fully understand the office policy and I will assume responsibility for fees associated with those procedures performed. I also consent to the use of email to communicate with myself, my insurance company, dental offices or specialists in the sending of receipts, statements, estimates, x-rays and any information requested by such for the process of predeterminations, claims or updating records.

**Patient/Guardian signature** __________________________________________ **Date** ______________________________________

| Date | Medical History Changes | Initials |
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SOUTHWOOD DENTAL

**Assignment of Benefits and Release of Information**

I hereby assign to **SOUTHWOOD DENTAL** any rights and privileges to which I am entitled to dental treatment in accordance with the rules and regulations governing my membership in my dental plan, or so much thereof as can be applied to reduce or discharge my indebtedness for expense incurred by me or by my dependents.

**Dental Office Personal Information Consent**

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 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 invoices 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"). 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:

- 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/my dependant's personal information as set out above. I authorize release of coverage/claim information to my dental provider.

**Patient/Guardian signature** ________________________________________ **Date** ____________________________________