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CONFIDENTIAL INFORMATION AND HEALTH HISTORY UPDATE

TODAYS DATE: ______________________

PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________ Middle Initial: ______

Date of Birth: ________________ Age: ______ Height: ______ Weight: ______ Preferred Pronouns: ______

If no contact information has changed, check box and initial. ☐ **No change** **Initials:** ______

Address: ____ City/Town: ______________

Postal Code: ____________ Email: ______________________________ Phone: __________

Personal Preferences:

We offer Neuromodulators (Botox/Xeomin), Invisalign, and Zoom! teeth whitening. Are you interested in learning more about any cosmetic dental options? ☐ yes ☐ no

Is there anything you would like to change about your smile? ______________________

MEDICAL HISTORY AND INFORMATION

Have you ever had or have any of the following? Please check that apply so that we may treat you safely:

- ☐ Acid Reflux
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Cancer
- ☐ Cold Sores
- ☐ COPD
- ☐ Dementia
- ☐ Dental Appt. Pre Med
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Domestic Violence
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Hearing Aids
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Hepatitis A / B / C (circle)
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Mental Health Issues
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ STD/STI
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Transplant Recipient/Donor
- ☐ TMJ Problems
- ☐ Tuberculosis
- ☐ Other: ______________________________

Please list your medications, dosage, and use

Medication:	Dosage:	Use:

List all allergies: ____

____

MEDICAL HISTORY AND INFORMATION

For the following, **circle Yes or No**, or fill in the blank where applicable:

Do you smoke cigarettes/cigars? Yes No
Do you use an e-cigarette? Yes No
Do you chew tabacco? Yes No
Do you use cannabis (marijuana)? Yes No
Do you use any other form of recreational drugs? Yes No Which ones? ___________________________
How many alcohol beverages do you consume each week? _______

What is your quality of sleep like? ____
Do you wake up to use the washroom? Yes No
Do you wake up gasping? Yes No
Do you wake up with acid in your mouth? Yes No
Does your partner complain of snoring? Yes No
Would you be interested in an Obstructive Sleep Apnea screening? Yes No

FOR WOMEN ONLY:
Are you taking Birth Control Pills or other Contraceptives? Yes No
Are you currently Pregnant? Yes No If yes, how many months? ________
Are you currently breast-feeding? Yes No

How would you rate your level of nervousness at the dentist? (1 being not at all nervous and 5 being very nervous)
Not at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very

Terms and Conditions (sign on following page)

Appointments:
Please help us maintain the operation of our office on sound principle so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore we will need at least 48 HOURS NOTICE to be given if cancellation is necessary. No show or last minute cancellations can result in a $100 cancellation fee.

Payment of Fees:
This office is willing to accept direct payment from your dental plan for services which your plan covers. If your dental plan does not cover the full cost of your treatment, you will be responsible for any difference between the amount paid by your plan and the amount charged. Your portion is then due and payable on the day of your appointment. You are responsible for providing necessary information in order for us to direct bill your insurance company as well as informing us of any changes in this information.

General Release:
I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history, and have not knowingly omitted any information. I also authorize the communication of information related to the coverage of serviced described in this form to the named doctor.

Consent:
I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated and consent to the use of local anesthetic agents. I understand the above statements regarding payment of fees and accept the responsibility for payment for dental services provided by myself or my dependents, due and payable when services are rendered unless other financial arrangements have been made.

Terms and Conditions Continued

Personal Information 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 summarized 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, addresses, phone 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 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, and condolences or congratulation messages.

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 purposed 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 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

Dentists in Alberta 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 have read the above, and I consent to the collection, use, and disclosure of my personal information as set out above.

Signature: ________________________ Date: ____________________

I accept this as my electronic signature for the purposes of this health history form

Relationship to Patient (if Patient is under 18 years of age): ____________________