Welcome to

iDENTAL

Please print and fill out this form prior to arriving at your appointment.

Please complete the following information:

First Name_____ Last Name_____

Address_____ City_____ Post Code_____

Home Phone_____ Work_____ Cell_____

Email Address_____

Male ___ Female___ Date of Birth_____ (Day/Month/Year)

If under 18 years of age, name of parent or guardian_____

Do you have Dental Insurance? Yes__ No__

Name of Policy Holder_____Date of Birth_____

Your relationship to policy holder: Self___ Spouse___ Dependant___

Place of Employment_____

Name of Insurance Company_____ Policy #_____

Certificate #_____ ID #_____

Are you claiming from more than one insurance plan? Yes ___ No ___

Second Plan

Name of Policy Holder_____Date of Birth_____

Your relationship to policy holder: Self___ Spouse___ Dependant___

Place of Employment_____

Name of Insurance Company_____ Policy #_____

Certificate #_____ ID #_____

iDENTAL PRIVACY POLICY

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, cellular phone numbers and email addresses (collectively referred to as "Patient Contact information"). Patient 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 for third-party health benefits providers and insurance companies.*
· *To send reminders to patients concerning the need for further dental examination or treatment.*
· *To send patients information material about our dental practice.*

Patient 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 will be collected in order to make arrangements for the payment of dental services provided unless the dental services are paid for in full at the time of visit.

We collect information from our patients about their health history, their family health history, physical condition, and previous 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 is 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 information is no longer required, all pertinent documents are destroyed using the services of Shred-It, an on-site, secure document destruction program developed specifically to deal with regulatory privacy and confidentiality requirements.

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.

___ Please check here to consent online - You will be asked to sign at your first appointment.

Date Print Name Signature

_____ _____ _____

Please ask to fill out ‘Our Insurance Express Check Out’ form
when you are at your first appointment.

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: Mr./Miss/Mrs./Ms./Dr.

_____

DATE OF BIRTH (DAY/MONTHY/YEAR: _____/_____/_____

ADDRESS (HOME):

_____

_____

PHONE: _____

ADDRESS (BUSINESS):

_____

_____

PHONE: _____

OCCUPATION: _____

WHO REFERRED YOU TO OUR OFFICE?

_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

DAY-TIME PHONE: _____

NAME OF FAMILY DOCTOR: _____

PHONE OR ADDRESS: _____

_____

_____

(1) NAME OF MEDICAL SPECIALIST: _____

AREA OF SPECIALTY: _____

PHONE OR ADDRESS: _____

(2) NAME OF MEDICAL SPECIALIST: _____

AREA OF SPECIALTY: _____

PHONE OR ADDRESS: _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

❒ YES ❒ NO ❒ NOT SURE/MAYBE

_____

2. When was your last medical checkup?

_____

3. Has there been any change in your general health in the past year? If yes, please explain.

❒ YES ❒ NO ❒ NOT SURE/MAYBE

_____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

❒ YES ❒ NO ❒ NOT SURE/MAYBE

_____

5. Do you have any allergies? If you answered yes, please list using the categories below:

❒ YES ❒ NO ❒ NOT SURE/MAYBE

a) medications
b) latex/rubber products
c) other e.g. hayfever, foods

_____

6. Have you ever had a peculiar or adverse reaction to any medications or injection? If yes, please explain.

❒ YES ❒ NO ❒ NOT SURE/MAYBE

_____

7. Do you have or have you ever had asthma? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

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8. Do you have or have you ever had any heart or blood pressure problems?
❒ YES ❒ NO ❒ NOT SURE/MAYBE

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9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
❒ YES ❒ NO ❒ NOT SURE/MAYBE

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10. Do you have a prosthetic or artificial joint? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

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11. Have you ever been advised by your doctor to take antibiotics before dental treatment?
❒ YES ❒ NO ❒ NOT SURE/MAYBE

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12. Do you have any conditions or therapies that could affect your immune system
e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

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13. Have you ever had hepatitis, jaundice or liver disease?
❒ YES ❒ NO ❒ NOT SURE/MAYBE

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14. Do you have a bleeding problem or bleeding disorder? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

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15. Have you ever been hospitalized for any illness or opertaions? If yes, please explain.
❒ YES ❒ NO ❒ NOT SURE/MAYBE

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16. Do you have or have you ever had any of the following? Please check.

❒ chest pain, angina	❒ shortness of breath	❒ pacemaker	❒ steriod therapy	❒ seizures(epilepsy)	❒ drug/alcohol dependancy
❒ heart attack		❒ lung disease	❒ diabetes	❒ kidney disease	
❒ stroke	❒ prosthetic heart valve	❒ tuberculosis	❒ stomach ulcers	❒ thyroid disease	
		❒ cancer	❒ arthritis	❒ diet pill therapy	

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17. Are ther any conditions or disease not listed above that you have or have had? If so, what?
❒ YES ❒ NO ❒ NOT SURE/MAYBE

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18. Are there any disease or medical problems that run in your family?
(e.g. diabetes, cancer or heart disease) ❒ YES ❒ NO ❒ NOTSURE/MAYBE

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19. Do you smoke or chew tobacco products? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

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20. Are you nervous during dental treatment? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

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21. **For women only:** Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?
❒ YES ❒ NO ❒ NOTSURE/MAYBE

To the best of my knowledge, the above information is correct:

PATIENT/ PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

DENTIST SIGNATURE: _____ **DATE:** _____

DENTIST'S NOTES