SHERBROOKE FAMILY DENTAL CLINIC
COMPREHENSIVE DENTISTRY
SERVICES PROVIDED BY GENERAL DENTISTS

NAME_____ AGE_____

DATE OF BIRTH _____MALE/FEMALE_____

ADDRESS_____CITY_____

POSTAL CODE_____HOME#_____

WORK#_____CELL#_____

HOW DID YOU HEAR ABOUT US?_____

EMAIL_____

INSURANCE #1	INSURANCE #2
POLICY HOLDER_____	POLICY HOLDER_____
DOB_____	DOB_____
EMPLOYER_____	EMPLOYER_____
INS. COMPANY_____	INS. COMPANY_____
GROUP/PLAN#_____	GROUP/PLAN#_____
ID/CERT.#_____	ID/CERT#_____

I understand that in order for us to provide direct billing to our patients, we will require our patients to provide us with a credit card on file. If we cannot calculate your balance at your dental visit, we will charge the balance to the credit card on file upon receiving payment from your insurance company

If you do not wish to leave your credit card on file with us, you will be required to leave a deposit following your appointment with us. This deposit will be based on your insurance coverage (80% coverage, a 20% deposit will be collected etc), this alternative may result in a small balance or credit on your account once insurance payment is received. It is important for you to understand that there may be a difference between our fees and what your insurance company will pay towards your treatment, and that you are responsible for any difference in fees.

Also I give consent to perform the dental and oral procedures deemed necessary for any treatment, including the use of local anesthetic and that I assume responsibility for the fees associated with those procedures.

If you are in understanding with each statement, please indicate by signing below.

Patient Signature _____

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Medical History Form

Patient Name: _____
Emergency Contact: _____ Phone: _____
Relationship: _____
Name of Family Doctor: _____ Phone: _____

Dental History

Have you had regular dental exams in the past? ___Yes ___No
Have you had dental x-rays in past year? ___Yes ___No
Have you had your teeth extracted in the past year? ___Yes ___No
Do you have any fixed bridges, partial dentures, full dentures? ___Yes ___No
Have the above replacements been satisfactory? ___Yes ___No
Have you ever had root canal therapy? ___Yes ___No
Have you ever had periodontal (gum) disease? ___Yes ___No
Have you ever had abscessed teeth, sore gums, sore mouth? ___Yes ___No
Do you have any habits that may affect your teeth?
Such as clenching, grinding, nail biting etc. ___Yes ___No

How often do you brush your teeth? _____
How often do you floss your teeth? _____
How often do you use mouthwash? _____

Medical History

Are you being treated for any medical condition at the present time or within the last year? ___Yes ___No
Details:
_____
When was your last medical check up?
_____
Has there been any change in your general health in the past year? ___Yes ___No
Details:
_____
Are you presently taking any medications? Please list below ___Yes ___No
_____

Do you have any allergies? ___Yes ___No
Details (Please list reactions):
_____

Do you have or have you ever had asthma? ___Yes ___No

Do you have or have you ever had any heart or blood pressure problems? ___Yes ___No

Do you have or have you ever had a heart murmur, mitral valve prolapsed or rheumatic fever? ___Yes ___No

Do you have a prosthetic or artificial joints ___Yes ___No?
Details: _____

Do you have any conditions or therapies that could affect your immune system?
I.e., leukemia, Aids, HIV infection, radiotherapy, chemotherapy?
Details: _____

Have you ever had hepatitis, Jaundice, or liver disease? ___Yes ___No
Details:
_____

Do you have a bleeding problem or bleeding disorder? ___Yes ___No
Details:
_____

Have you ever been hospitalized for any illness or operations? ___Yes ___No
Details:
_____

Do you have or have you ever had any of the following? Please Check

__chest pain/angina	__shortness of breath	__pacemaker	__steroid therapy
__seizures (epilepsy)			
__heart attack	__lung disease	__diabetes	__kidney disease
__stroke			
__prosthetic heart valve	__tuberculosis	__stomach ulcers	__thyroid disease
__cancer	__arthritis	__diet pill therapy	

Are there any conditions or disease not listed above that you have or have had? ___Yes ___No
Details:
_____

Are there any diseases or medical problems that run into your family? ___Yes ___No
Details:
_____

Do you drink alcohol and if so, how often? ___Yes ___ No
_____

Do you or have you ever used recreational drugs? ___ Yes ___ No
Details (Please list):
_____

Do you smoke or chew tobacco products? ___Yes ___No
Are you nervous during dental treatment? ___Yes ___No
For Women Only: Are you breast-feeding or pregnant? ___Yes ___No

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

Signature: _____ Date: _____

Dental Office Personal Consent Form

We are committed to protecting the privacy of our patient's personal information and 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, 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.

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment for 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 for 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 a 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 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.

_____	_____	_____
Date	Print Name	Signature (Parent or Guardian)