Personal Information Consent Form

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, 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 payments 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 provides 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 a second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to other dentists or dental specialists 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 are professionals such as physicians if the patient, with their consent has been referred by us to 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 College of Dental Surgeons of Alberta 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.

_____	_____	_____
Print name	Signature	Date

PATIENT INFORMATION

Certain information is necessary for proper diagnosis, treatment, and for our records.
All Information is held in strict confidence.
Please answer to the best of your knowledge the questions listed below

Name:_____
Last First Middle

Marital Status:_____Parent/Spouse Name:_____
Home Address:_____PC:_____
Home Phone:_____Mobile Phone:_____
Occupation:_____Employer:_____
Email:_____
Date of Birth_____

IN CASE OF EMERGENCY, CONTACT:_____
PHONE:_____Email:_____

BENEFITS INFORMATION

PRIMARY INSURANCE
Policy Holder:_____DOB:_____
Employer: _____Insurance Provider:_____
Policy/Group#:_____ID/Certificate#:_____

SECOND INSURANCE
Policy Holder:_____DOB:_____
Employer: _____Insurance Provider:_____
Policy/Group#:_____ID/Certificate#:_____

Whom may we thank for introducing you to our office:_____

MEDICAL HISTORY: 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 anything that you do not understand. Please fill in the entire form.

Family Doctor:_____

Clinic's phone number: _____

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

_____

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

_____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. Yes /No

_____

_____

_____

5. Do you have any allergies? Yes/ No .If yes, please list using the categories below:

a) medications

_____

b) latex/rubber products

_____

c) other (e.g. hayfever, foods)

_____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? Yes /No. If yes, please explain

_____

7. Do you have or have you ever had asthma? Yes /No

8. Do you have or have you ever had any heart or blood pressure problems?

Yes /No

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Yes / No

_____

10. Do you have a prosthetic or artificial joint? Yes/ No

11. Do you have any conditions or therapies that could affect your immune system, (i.e. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? Yes/ No

12. Have you ever had hepatitis, jaundice (other than at birth) or liver disease?
Yes /No

13. Do you have a bleeding problem or a bleeding disorder? Yes/ No . If Yes please list which.

_____

14. Have you ever been hospitalized for any illnesses or operations?
If yes, please explain. Yes/ No

_____

15. Do you have or have you ever had any of the following? Please circle. chest pain, angina rheumatic fever, lung disease, stomach ulcers, drug/alcohol heart attack ,mitral valve ,tuberculosis ,arthritis ,dependency stroke, prolapse ,cancer ,seizures (epilepsy) ,osteoporosis , heart murmur, steroid therapy, kidney disease medications, pacemaker ,diabetes ,thyroid disease.

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? Yes/ No

_____

17. Are there any diseases or medical problems that run in your family?(e.g. diabetes, cancer or heart disease) Yes /No

_____

18. Do you smoke or chew tobacco products? Yes /No .How many per day?_____
Number of years?_____

FOR WOMEN ONLY

1. Are you pregnant? Yes No Not Sure/Maybe Expected delivery date?

_____

2. Are you breastfeeding? Yes No
3. Are you taking birth control medication? Yes No