PARKSTONE DENTAL

New Patient Health History Form

Title: _____ Given Name: _____ Surname: _____

Address: _____

City: _____ Postal Code: _____ Province: _____

Date of Birth: _____ (MM/DD/YYYY) Gender: M/F Marital Status: S/M/W/D

Home #: _____ Cell #: _____ Work #: _____

Email: _____

Who can we thank for referring you to out office: _____

Emergency Contact Information

Name: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____

Request for Confidential Communication

As my dental care provider, you may contact me regarding dental appointments and treatment with my permission by:

At home	Yes/No
My cell phone	Yes/No
At work	Yes/No
Via Email	Yes/No

Patient Consent for Dental Treatment

I consent to the performing of dental and oral surgery procedures performed by Dr. Jefferies and/or Dr. Voravong agreed to be necessary or advisable, including the use of local anesthetic and I will assume responsibility for fees associated with these procedures.

_____ _____

Patient (Parent/Guardian) Signature Date (MM/DD/YYYY)

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Insurance Assignment of Benefits Authorization and Payment Policy

I authorize release of my dental benefits plan administrator and the Canadian Dental Association information in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to Dr. Jefferies and/or Dr. Voravong. This authorization shall continue in effect until the undersigned revokes.

I acknowledge that, it is my sole responsibility to know and understand my dental policy calendar year, maximum limits, deductibles and coverage frequencies and limitations.

Parkstone Dental will accept assignment from your insurer, providing a valid credit card is left on file. If you do not wish to leave a credit card on file, then payment is required as services is considered rendered. This office reserves the right to automatically apply any overdue balances of 30 days to the credit card noted below as per the Health Information Act.

Credit Card Information

Type: VISA/MC/AMEX Card # _____ Exp Date: _____

By my signature below I also agree to make full payment to Parkstone Dental of any portion not covered by my insurance provider. In the even of insufficient funds a $50 NSF fee will be incurred, If the payment should not be delivered at all, Parkstone Dental will be entitled to refer this matter to a debt collection service.

_____ _____

Patient (Parent/Guardian) Signature Date (MM/DD/YYYY)

*** A $50 cancellation fee will be charged to any patient who is unable to give Parkstone Dental at least 24 hours notice of any scheduled appointment. ***

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Medical History

Dental professionals primarily treat the area in and around your mouth, but since your mouth is part of your body, any medication you are taking and your health history have an important relationship with your dental treatment. Please answer the following questions.

Are you currently seeing a Family Physician? Yes/No
If so, please provide their name and contact info. _____

Have you recently (in the last 2 years) been hospitalized or had a major operation? Yes/No
Please explain. _____

Have you ever had a serious head, neck or jaw injury? Yes/No
If so, please explain. _____

Are you or could you be pregnant? Yes/No

Please go over the following section and indicate which of the following you have or have had. If you need to add any further information, please enter it at the end.

Aids/HIV	Yes/ No	Chest Pains	Yes/No	Hepatitis B/C	Yes/No
Alzheimer's	Yes/No	Circulation Problems	Yes/No	High Blood Pressure	Yes/No
Anaphylaxis	Yes/No	Diabetes	Yes/No	Kidney Problems	Yes/No
Anemia	Yes/No	Emphysema	Yes/No	Liver Problems	Yes/No
Arthritis	Yes/No	Epilepsy/Seizures	Yes/No	Lung Disease	Yes/No
Artificial Joint	Yes/No	Fainting	Yes/No	Mental/Nervous Dis	Yes/No
Asthma	Yes/No	Glaucoma	Yes/No	Neurological Dis	Yes/No
Autoimmune	Yes/No	Heart Attack	Yes/No	Organ Transplant	Yes/No
Blood Disease	Yes/No	Heart Murmur	Yes/No	Rheumatic	Yes/No
Bruise easily	Yes/No	Heart Pacemaker	Yes/No	Stomach Ulcer	Yes/No
Cancer	Yes/No	Hemophilia	Yes/No	Stroke	Yes/No
Chemo	Yes/No	Heart Surgery	Yes/No	Thyroid Deficiency	Yes/No
Cold Sores	Yes/No	Hepatitis A	Yes/No	Tuberculosis	Yes/No

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Medical History cont.

Please list any other illnesses not included above:

_____

_____

Please list any prescriptions or non-prescription medicine you are currently taking or have taken recently:

Medication_____ Reason _____

Medication_____ Reason _____

Medication_____ Reason _____

Medication_____ Reason _____

Do you have any allergies? If so, to what:

_____

_____

Do you use any form of tobacco?	Yes/No
Are you dependent on alcohol or drugs?	Yes/No
Do you have severe earaches, ear/throat infections, or headaches?	Yes/No

Please note that it is your responsibility to update our office of any changes that may occur to your medical history.

_____ _____

Patient (Parent/Guardian) Signature Date (MM/DD/YYYY)

PARKSTONE DENTAL

Dental History

In the following section, please select whichever applies. Your answers are for our records and will be kept confidential in accordance with the Health Information Act. Please note that during your initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

If you have a current dental problem, please describe:

_____

_____

Do you have any other concerns about having dental treatment? If so, please explain.

_____

_____

Do you ever feel nervous about visiting the dentist? If so, please explain.

_____

_____

Please give a brief description of your oral hygiene habits (how often do you receive cleanings):

_____

_____

Date of your last teeth cleaning: _____(MM/DD/YYYY)
Date of your last dental x-rays: _____(MM/DD/YYYY)
Date of your last dental exam: _____(MM/DD/YYYY)

Do your gums bleed when brushing or flossing?	Yes/No
Have you ever had Periodontal treatment (gums)?	Yes/no
Are your teeth sensitive to cold, hot, sweets, or pressure?	Yes/No
Do you feel pain to any of your teeth?	Yes/No
Do you have any sores or lumps in your mouth?	Yes/No
Do you have any loose teeth, or have they ever shifted?	Yes/No

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Dental History Cont.

Does food frequently get caught in your teeth?	Yes/No
Do you bite your lips or cheeks frequently?	Yes/No
Do you have headaches or migraines?	Yes/No
Have you had any difficult extractions in the past?	Yes/No
Have you ever worn a bite plate or other appliance?	Yes/No
Have you ever had difficulty opening or closing your jaw?	Yes/No
Have you ever had pain n your jaw area?	Yes/No
Have you ever had trouble with local anesthetic/freezing	Yes/No

Are you happy with the appearance of your teeth? If not, please explain.

_____

_____

What can we do to make you smile? Check all that apply, and we'll get back to you with more information about your inquiry:

Veneers	Oral Sedation	Broken/Cracked Teeth	Invisalign
Implants	Dentures	Whitening	Replace metal fillings

Please note that it is your responsibility to update our office of any changes that may occur to your dental history.

_____ _____

Patient (Parent/Guardian) Signature Date (MM/DD/YYYY)

PARKSTONE DENTAL

Personal Information Patient Consent Form – In accordance to the Health Information Act

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, addresses, telephone numbers, and email addresses. 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 send the reminders to the patients concerning the need for further dental appointments

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 is collected for payment purposes, it is not shared with third parties without your consent, unless permitted by law for outstanding bill collection purposes.

We collect information from our patients about their health history, physical condition and dental treatments. Patients' medical information is collected and used for diagnosing dental conditions and providing dental treatment. Patients medical information is disclosed:

- To third party benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of al or part of the cost of dental treatment or has asked us to submit a claim on the patients' behalf.
- To other dentists and dental specialists, or to other health care professionals.

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.

_____ _____

Patient (Parent/Guardian) Signature Date (MM/DD/YYYY)