NAME: _____

ADDRESS: _____ POSTAL CODE: _____

AGE: _____ BIRTH DATE: D/ _____ M/_____ Y/ _____ PH. RES.: _____ PH. BUS.: _____

REFERRED OR RECOMMENDED BY: _____

EMPLOYER: _____

INSURANCE INFORMATION: _____

SPOUSE'S INSURANCE: _____

NAME: _____ BIRTH DATE: D_____ / M_____ / Y_____

DVA NUMBER: _____ PHN #: _____

PRESENT DENTURE AGE: UPPER - _____ LOWER: _____

PRESENT DENTURES MADE BY: _____

LAST DENTAL WORK, DATE & PRACTITIONER: _____

PERSONAL DENTIST: _____ PH. NUMBER: _____

PERSONAL PHYSICIAN: _____ PH. NUMBER: _____

ADDITIONAL INFORMATION: _____

I, the undersigned, hereby certify the information given by me to be accurate, and I assume responsibility for all fees incurred.

Patient Signature: _____ Date: _____

Email Address _____

MEDICAL HISTORY:

1. ☐ Yes ☐ No Are you in good health at the present time? _____
2. ☐ Yes ☐ No Are you under the care of a physician at the present time? _____
3. ☐ Yes ☐ No Are you on any medications at the present time? _____
4. ☐ Yes ☐ No Are you allergic to any medications? _____
5. ☐ Yes ☐ No Is there any history of family disease? What? _____
6. ☐ Yes ☐ No Do you have or have you had any of the following conditions? (Please check applicable conditions)

☐ AIDS	☐ Chronic Headache	☐ Hepatitis	☐ Rheumatic Fever
☐ Allergies	☐ Diabetes	☐ High / Low Blood Pressure	☐ Sexually Transmitted Disease
☐ Anemia	☐ Dry Mouth	☐ HIV Infection	☐ Sinusitis
☐ Arthritis	☐ Epilepsy	☐ Kidney Disorder	☐ Stroke
☐ Bleeding Disorder	☐ Facial Muscle Pain	☐ Menopause	☐ Thyroid Disorder
☐ Breathing Disorder	☐ Gastrointestinal Disorder	☐ Mental / Nervous Disorder	☐ Tuberculosis
☐ Cancer	☐ Heart Disease	☐ Migraine Headaches	☐ Other: _____

7. ☐ Yes ☐ No Do you smoke or use chewing tobacco? _____
8. ☐ Yes ☐ No Have you ever had x-ray for tumor of growth in your head, neck, or mouth? _____
9. ☐ Yes ☐ No Have you had serious injury, surgery, or x-ray therapy to your head, neck, or mouth? _____
10. ☐ Yes ☐ No Do you bruise easily, or bleed abnormally? _____
11. ☐ Yes ☐ No Are you pregnant? _____
12. ☐ Yes ☐ No Have you had a recent change in weight? _____ If yes, how much? _____
13. ☐ Yes ☐ No Are you on a diet? Personal choice: _____ Physician's order: _____
14. ☐ Yes ☐ No Do you have any habits that may affect your teeth, such as clenching, grinding, nail biting, etc.? _____

_____

Personal Information Protection Act Consent Form

In our office, we are dedicated to ensuring the protection of our patients' personal information and insuring that this information is used only in a professional manner. The following indicates some of the information that is collected, why we collect it, and when we may disclose your personal information. We collect, use and disclose your personal information where permitted or required by law.

Contact Information

We collect contact information from our patients such as full name, home address, home telephone number(s), work telephone number(s), cellular phone number(s). This information is considered as Contact Information and it is collected for a variety of purposes including the following:

- To open and update a patient file;
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts;
- To process claims for payment or reimbursement from a third-party health benefit provider or insurance company*
- To correspond by mail or by telephone to our patients regarding need for further examination or treatments; and
- To send correspondence to our patients regarding our clinic and practice.

* Contact information is/may be disclosed to a third party health benefit provider or insurance company when submitting a claim on the patients' behalf, for payment or reimbursement of all or part of the cost of the treatment provided, or when a patient has requested a preauthorization of a proposed treatment.

Medical/Dental History

We collect from our patients, information about their health history, family health history, physical and mental condition, their dental health history and family dental health history. This Medical/Dental information is collected for a variety of purposes and may be used in part to assist us in diagnosing dental conditions and providing appropriate treatment for you, and may be disclosed for the following purposes:

- To a third-party health benefit provider or insurance company, in the submission of a claim on behalf of the patient, for reimbursement of payment of all or part of the cost of the treatment;
- To a third-party health benefit provider or insurance company on behalf of the patient, in the submission of a preauthorization of treatment;
- To other health/dental providers where, upon your consent, we are seeking a second opinion;
- To other health/dental providers where, upon your consent, we have referred you to additional/alternative treatment.

Future Use

If consideration to sell this practice or a portion of this practice ever occurs, and qualified potential purchasers may be granted access as part of due diligence process to patient information, in order to verify information related to the sale. If this ever occurs, we will take necessary steps to ensure that the prospective purchaser protects any personal information, as we have done.

Regulatory

The College of Alberta Denturists regulates all Denturists in the Province of Alberta, and as part of their regulatory function, may inspect our records and interview our staff in the process of their duties.

Consent

I hereby authorize and consent to the collection, use and disclosure of personal information concerning my self with regards to the above purposes.

Date at the City of _____, in the Province of Alberta on the _____day of _____, 20_____.

_____
(Patient Signature)

_____
(Print Name)