MEDICAL HISTORY QUESTIONNAIRE

NOSE CREEK DENTAL CENTRE

LEGAL NAME:_____

Preferred Name: _____

DATE OF BIRTH: (DAY/MONTH/YEAR):

_____

HOME ADDRESS:

_____

CITY: _____

POSTAL CODE: _____

HOME: _____

CELL: _____ _____

WORK: _____ _____

EMAIL: _____

EMPLOYER: _____ _____

PATIENT CHART #_____(OFFICE USE ONLY)

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

DAY-TIME PHONE: _____

FAMILY PHYSICIAN: _____

PHONE: _____

WHO REFERRED YOU:

_____

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 dental check up?

_____

3. Has there been any change in your general health in the past year? If yes, please explain. **Yes** **No** **Not Sure/Maybe**

_____

4. Do you currently have any of the following? Please Circle

Coughing **High fever** **Open Sores** **Vomiting** **Diarrhea**

5. Are you taking or have you taken any medications, Blood Thinners, non-prescription drugs, herbal supplements or CBD Oil in the past 6 months? (e.g. Vitamins, Dietary supplements, Herbal supplements) **Yes** **No** **Not Sure/Maybe**
If yes, please list…

_____

5b: Have you used cocaine, marijuana or any other drugs in the past year? Please List… **Yes** **No** **Not Sure/Maybe**

_____

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

Yes No Not Sure/Maybe

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

6b: Have you been diagnosed with any new allergies in the past year? **Yes No Not Sure/Maybe**

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7. Have you ever had a peculiar or adverse reaction to any medicines or injections? **Yes No Not Sure/Maybe**
If yes, please explain.

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8. Do you have or have you ever had Asthma? **Yes No Not Sure/Maybe**

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9. Do you have or have you ever had any Heart or Blood Pressure problems?
Yes No Not Sure/Maybe

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10. Do you have or have you ever had an artificial heart valve, a history of infective endocarditis, a heart transplant or a congenital heart defect?
Please List: **Yes No**

10b: Do you have a pace maker? **Yes No Not Sure/Maybe**

11. Do you have a prosthetic or artificial joint? **Yes No Not Sure/Maybe**

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12. Have you ever been advised by your doctor to take antibiotics before dental treatment?
Yes No Not Sure/Maybe

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13. Do you have any conditions or therapies that could affect your immune system: Please Circle? Yes No Not Sure/Maybe

Leukemia AIDS HIV infection Radiotherapy Chemotherapy Rheumatoid Arthritis Lupus

14. Have you ever had hepatitis A, B, or C, jaundice or liver disease?
Yes No Not Sure/Maybe

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15. Do you have a bleeding problem or bleeding disorder? **Yes No Not Sure/Maybe**

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16. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
Yes No Not Sure/Maybe

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17. Do you have or have you ever had any of the following? Please circle.

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

18. Are there any conditions not listed above that you have or have had? If so, what? **Yes** **No** **Not Sure/Maybe**

_____

19. Are there any diseases or medical problems that run in your family?
(e.g. diabetes, cancer or heart disease) **Yes** **No** **Not Sure/Maybe**

_____

20. Are you taking or have you taken Bisphosphonate Therapy (bone density medication)? If so, how long?
(E.g. Actonel, Boniva, Fosamax, Skelif, Didronel) **Yes** **No** **Not Sure/Maybe**

_____

21. Do you smoke, chew tobacco, or vape? **Yes** **No** **Not Sure/Maybe**

_____

22. Are you nervous during dental treatment? **Yes** **No** **Not Sure/Maybe**

_____

23. Have you ever had difficulty becoming anesthetized (numb) for dental procedures? **Yes** **No** **Not Sure/Maybe**

_____

24. <u>For Women Only</u>: Are you pregnant or breast feeding? If pregnant, what is the expected delivery date? **Yes** **No** **Not Sure/Maybe**

_____

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

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

I UNDERSTAND and agree that I AM RESPONSIBLE for payment of all dental services provided to me and/or my dependents. I hereby assign my benefits, payable from claims submitted electronically or manually, to Nose Creek Dental Centre and authorize payment directly to the providing dentist.

Please be advised that it is your responsibility to understand your Insurance Guidelines.

_____ _____

Signature of Patient/Parent or Guardian **Date**

INSURANCE INFORMATION (Primary Plan)

Name of Insured: _____

D.O.B. Day _____ Month _____ Year _____

Address: _____ Postal Code: _____

Home Phone: _____ Work: _____ Ext: _____ Cell: _____

Name of Employer: _____ Name of Ins. Company: _____

Group/Policy No. _____ Cert./ID No. _____ Cov. No. _____

INSURANCE INFORMATION (Secondary Plan if applicable)

Name of Insured: _____

D.O.B. Day _____ Month _____ Year _____

Address: _____ Postal Code: _____

Home Phone: _____ Work: _____ Ext: _____ Cell: _____

Name of Employer: _____ Name of Ins. Company: _____

Group/Policy No. _____ Cert./ID No. _____ Cov. No. _____

INSURANCE INFORMATION (Third Plan if applicable)

Name of Insured: _____

D.O.B. Day _____ Month _____ Year _____

Address: _____ Postal Code: _____

Home Phone: _____ Work: _____ Ext: _____Cell: _____

Name of Employer: _____ Name of Ins. Company: _____

Group/Policy No. _____ Cert./ID No. _____ Cov. No. _____

CONSENT FOR COLLECTION AND RELEASE OF INFORMATION

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 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, email addresses, credit card information, social insurance numbers and private dental insurance information. (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, and 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 materials.
- To follow up with treatment and/or customer service.

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 patients behalf.

Financial information may be collected in order to make arrangements for the payment of dental services or to provide a form of security of payment.

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.

Patients Medical Information is disclosed for the following purposes:

- 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 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 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.

_____	_____	_____
DATE	PRINT NAME	SIGNATURE

Office Policies

We at Nose Creek Dental Centre believe that clarity is the key to a good relationship. In an effort to ensure your appointments are as pleasant and predictable as possible we would like to give you an overview of our office policies. Please feel free to call us with any questions you may have.

About Direct Insurance Billing

Due to the Canadian Personal Privacy Act, we are unable to access any sufficient information from your insurance company regarding your dental plan. It is your responsibility to know the details involved in your plan such as annual maximums, frequencies, and any other limitations. We extend the courtesy to bill your insurance directly, however, to avoid any patient portion discrepancies please be fully aware of the particulars of your plan so you can utilize your benefits to the maximum.

Your Appointment Reminders

Please understand that it is your responsibility to keep track of your appointments and we do everything we can to remind you of them in adequate time for you to make arrangements or changes for that appointment. As a courtesy we either send out a reminder card or email one month prior to an advanced book hygiene appointment. We then send out an email four days ahead or call two days ahead to confirm your appointment. At this point we do require you to confirm your appointment with us either by email, or phone call. If you are unable to call during our regular office hours you can leave a message on our answering machine.

Our Cancellation Policy

Due to a continuous high demand in prime time appointments, we require a minimum of 48 hours' notice per appointment should you need to reschedule your appointment. This is valuable time that the Doctor has reserved for you. We reserve the right to charge a fee for short notice cancellations or failed appointments.

Our desire is for you to have a pleasant experience in our office. We strive to serve you to the best of our ability in helping you attain maximum dental health.
I have read and understood the above policies.

_____ _____

Patient/Guardian Signature Date