RIVERSIDE DENTAL CLINIC

CONFIDENTIAL PATIENT INFORMATION SHEET

PATIENT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH / / M D Y	SEX ☐ M ☐ F
HOME PHONE	MOBILE PHONE		WORK PHONE	
PREFERRED CONTACT NUMBER ☐ HOME ☐ WORK ☐ CELL		PLEASE SEND APPOINTMENT REMINDERS ☐ SMS TEXT ☐ EMAIL ☒ BOTH		
ALBERTA HEALTH CARE NUMBER		E-MAIL ADDRESS*		
PATIENT'S MAILING ADDRESS	CITY	PROV.	POSTAL CODE	
PATIENT'S GUARDIAN IF UNDER 18	RELATIONSHIP	DATE OF BIRTH / / M D Y		
MAIN CONTACT PHONE	EMPLOYER	WORK PHONE		

EMERGENCY CONTACT (DIFFERENT TO YOUR FAMILY HOME)

NAME	RELATIONSHIP	MAIN CONTACT PHONE	WORK PHONE

IF THIS IS YOUR FIRST VISIT, HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Facebook ☐ Web ☐ Other: ☐ Referred by another person:

*Please opt-out my e-mail for promotional material, BUT continue to use for appointment reminders ☐ opt-out

ASSIGNMENT OF BENEFITS AND PAYMENT POLICY

DO YOU HAVE DENTAL INSURANCE COVERAGE?

If yes, please provide our reception staff with your benefit card and information.

Primary Coverage ☐ Yes ☐ No	INSURANCE COMPANY	Secondary Coverage ☐ Yes ☐ No	INSURANCE COMPANY

This office is willing to accept direct payment from your dental plan, should your plan allow for assignment of benefits, for the cost of those dental services which we may provide and which your plan covers.

Dental plans in the marketplace today are too numerous and varied to allow us to know the details of all of them. Your particular dental plan may or may not cover the full extent of the costs you incur for your dental treatment. This can occur because the fees in our office are based on factors which may not have been considered by your insurance carrier. Furthermore, there may be certain procedures performed which are not covered through your dental plan. These factors are beyond our control.

PLEASE REVIEW YOUR DENTAL PLAN VERY CAREFULLY TO ENSURE YOU UNDERSTAND THE EXCLUSIONS AND LIMITATIONS OF YOUR PLAN. IF YOUR DENTAL PLAN DOES NOT COVER THE FULL COST OF TREATMENT, YOU WILL BE RESPONSIBLE FOR ANY DIFFERENCE BETWEEN THE AMOUNT PAID BY YOUR PLAN AND THE AMOUNT CHARGED FOR YOUR TREATMENT.

Payment for dental services is expected when treatment is rendered. You will be informed of your payment or co-pay responsibility at the time treatment is completed so that you may make payment at that visit. A 2% service charge will be applied to all account balances outstanding for more than 30 days.

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for any claim. I authorize that the doctor can use my records if he/she so determines.

I certify that I have read or had read to me the contents of this form, filled in completely and accurately to the best of my knowledge and do realize the risks and limitations involved.

PATIENT/GUARDIAN SIGNATURE_____ **Date**_____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician (Medical Doctor)/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ latex		
☐ metals (nickel, gold, silver, _____)		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. ☐high or ☐low blood pressure (**Please Check one**) _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis, rheumatoid arthritis, lupus _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries - **Specify:** _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. STI / STD - **Specify:** _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy, immunosuppressive _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol/street drug use - **Specify:** _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. experiencing frequent headaches _____	☐	☐
52. a smoker, smoked previously or use smokeless tobacco _	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

PATIENT/GUARDIAN SIGNATURE _____ **Date** _____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/___
Date of most recent treatment (other than a cleaning) _____/_____/___
I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _ _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning sensation in your mouth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
25. Are your teeth crowding or developing spaces? _____	☐	☐
26. Do you have more than one bite and squeeze to make your teeth fit together? _____	☐	☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
28. Do you clench your teeth in the daytime or make them sore? _____	☐	☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
30. Do you wear or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS		
31. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
32. Have you ever whitened (bleached) your teeth? _____	☐	☐
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
34 Have you been disappointed with the appearance of previous dental work? _____	☐	☐

PATIENT/GUARDIAN SIGNATURE_____ **Date**_____

Riverside Dental Clinic Personal Information Consent Form

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, home addresses, home and/or work 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 and/or legal guardians or persons financially responsible for patient accounts, for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party benefit providers, insurance companies and government agencies.
- 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 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 from whoever has been written as financially responsible for the account.

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"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed:

- To all third-party benefit providers, insurance companies and government agencies where a claim is being submitted for reimbursement or payment of all or part of the cost of dental treatment.
- To other dentists and dental specialists, where further information and/or discussion is required.
- To other dentists and dental specialists if the patient has been referred by us to the other dentist of dental specialist for treatment.
- To other health care professionals such as physicians if the patient has been referred by us to the other health care professional for either a second opinion or treatment.
- Where we are seeking and/or providing information to the following: laboratories, radiology centres, hospitals, etc.
- To include the following when necessary, such as: videos, pictures, slides, etc., for educational purposes.

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 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 interests.

I consent to the collection, use and disclosure of my personal information as set out above.

PATIENT/GUARDIAN SIGNATURE_____ **Date**_____