MEDICAL & DENTAL HISTORY FORM

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ (DD MM Year) Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) _____ (Province) _____ (Postal Code)

Whom may we thank for referring you to our practice?

☐ Website ☐ Sign ☐ Internet ☐ Yellowpages ☐ School ☐ Other: _____

Name the person, office, or other source referring you to our practice: _____

Emergency Contact Info: Name and Relationship and Phone Number:

PRIMARY INSURANCE

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Group/Plan/Policy#: _____ ID/Certificate#: _____ Plan Holder's Date of Birth: DAY/MONTH/YEAR _____

SECONDARY INSURANCE

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Group/Plan/Policy#: _____ ID/Certificate#: _____ Plan Holder's Date of Birth: DAY/MONTH/YEAR _____

Medical History

HAVE YOU EVER BEEN, OR DIAGNOSED WITH, ANY OF THE FOLLOWING?

☐ Allergy - Codeine	☐ Allergy - Ibuprofen	☐ Allergy -Latex	☐ Allergy - Other*
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Allergy - Erythromicin	☐ Allergy - Freezing
☐ Anemia	☐ Arthritis	☐ Asthma	☐ Blood Disorder
☐ Bypass Surgery/Stent	☐ Cancer	☐ Chemotherapy	☐ Chest Pain/Angina
☐ Congenital Disorder	☐ Creutzfeld Jacob	☐ Diabetes	☐ Epilepsy/Seizures
☐ Excessive Bleeding	☐ Excessive Bruising	☐ Gastro-Intestinal	☐ Genetic Disorder
☐ Glaucoma	☐ Head Injury	☐ Hearing Disabled	☐ Heart Disease
☐ Heart Murmur	☐ Heart Valve replaced	☐ Hepatitis A	☐ Hepatitis B
☐ Hepatitis C	☐ High Blood Pressure	☐ HIV + (AIDS)	☐ Joint Replacement
☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure	☐ Mental Disorders
☐ Multiple Sclerosis	☐ Neurologic Disorders	☐ Osteoporosis	☐ Pacemaker
☐ Prion Disease	☐ Prostate Disorder	☐ Radiation Treatment	☐ Respiratory Problem
☐ Rheumatic Fever	☐ Sinus Problem	☐ STD	☐ Steroid Therapy
☐ Street Drug Use	☐ Stroke	☐ Superbugs- MRSA/VRE	☐ Taking Medications
☐ Thyroid Disease	☐ Tobacco Use	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Weight Fluctuation	☐ Wheelchair	

Please provide details of above condition or any other health concerns not listed:

Are you taking any medications (Prescription or non-prescription), herbal supplements, vitamins?
If so, what? (name, dose and frequency)

Height:

Weight:

Have you ever taken antibiotic pre-medication for dental treatment? ◯ Yes ◯ No

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Are you breast feeding? ◯ Yes ◯ No

Your Primary Care Physician's name, address, & phone number:

What is the date (or approximate date) of your last medical exam? _____

Are you presently under the care of a physician? If so, why?

Dental History

What is the reason for your dental visit today?

Have you ever experienced any of the following?

☐ Frequent Headaches ☐ TMJ/Jaw Problems ☐ Bleeding Gums ☐ Braces/Orthodontics

☐ Receding Gums ☐ Loose teeth ☐ Shifting teeth

Do you currently have any of the following:

☐ Dental Implants ☐ Full Dentures ☐ Partial Dentures ☐ Night Guard

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Prior Dentist`s name, address, & phone number:

When was your last visit to the dentist (if at a different office)? _____

What was done on your last dental visit (if at a different office)?

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature: _____ Date: _____

Relationship to Patient: Self / Guardian / Parent (circle)

Attending Dentist: _____ Date: _____

Signature: _____

Oliver Park Dental
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780-705-6990

Privacy Information Policy In Compliance with the Federal Personal Information Protection Electronic Documents Act PIPEDA), Alberta's Personal Information Protection Act (PIP) and the Health Information Act (HIA) Oliver Park Dental has created the following policy to ensure the privacy of our patients and staff are protected.

Privacy of your personal information is an essential part of providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly, and strive to be open as possible with you about the way we handle your information.

The personal information that we collect is necessary to provide you with the appropriate care. This includes contact information, medical information and financial information. Once information is collected we ensure it remains secure. We do not share your information outside our office for any marketing, promotional, publicity pr research purposes without your specific consent.

Personal Information and Privacy Consent form

By signing this form. I agree that Oliver Park Dental can collect and disseminate my personal information on an ongoing basis (including contact information, financial information, and relevant medical information) as required for the following purposes:

- To open and update Patient files.
- To provide appropriate dental treatment.
- To invoice Patients for dental services, to process payment, or to collect unpaid accounts
- To process claims for reimbursement from 3rd party health benefit providers and insurance companies
- To contact Patients regarding the need for further examination, treatment or information.
- To provide other Dentists or Dental Specialist relevant information necessary for a second opinion or treatment.
- To provide continuity of care in the event of practitioner change within Oliver Park Dental.
- To allow for transfer of x-rays between professional offices (Dentist, Dental Specialists)

I understand that Oliver Park Dental only collects my personal information in order that they may provide me with appropriate care.

Signature: _____ Date: _____

Relationship to Patient: Self / Guardian / Parent (circle)