

Westview Dental
3020 Granville Drive N.W.
Edmonton AB T5T 4V3
780-487-6453

Chart #. _____

FOR OFFICE USE ONLY

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 Prev. Visit: _____ Email Address: _____

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

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?

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

I authorize Westview Dental to confirm appointments via e-mail.

Signature: _____

Date: _____

Relationship to Patient: Self / Guardian / Parent (circle)
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Attending Dentist: _____

Date: _____

Signature: _____

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Privacy Information Policy

In Compliance with the Federal Personal Information Protection Electronic Documents Act (PIPEDA), Alberta's Personal Information Protection Act (PIPA) and the Health Information Act (HIA) Westview 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 or research purposes without your specific consent.

Personal Information and Privacy Consent form

By signing this form, I agree that Westview 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 Westview Dental.
- To allow for transfer of x-rays between professional offices (Dentist, Dental Specialists)

I understand that Westview 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)