EGUREN DENTISTRY SOUTH

Dental Office 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.

All staff members who come into contact with your personal information are aware of the sensitive nature of it. In this office, **Marita Echaiz** acts as the Privacy Information Officer. Do not hesitate to discuss our policies with her. Please be assured that every staff member in our office is committed to ensuring that you receive the best quality dental care.

We collect information from our patients such as names, age, home addresses, work addresses, home telephone numbers, cell numbers, 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 for dental services, to process credit card payments, or 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 to further dental examination or treatment.
- To send patients information 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.

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 third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement of payment of all or part of the cost of dental treatment or has asked us to submit a claim in 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 the 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 public interest.

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

Date	Print Name	Signature

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MEDICAL CONSENT FORM

Medical History Form

Patient Name:_____

D.O.B:_____ Place of Birth: _____

Address: _____Postal Code: _____

Home Phone #:_____Cell Phone#:_____ Height: _____ Weight: _____

Email: _____ FT Student Y/N, School: _____

Emergency Contact: _____ Phone #: _____

Physician Name:_____ Phone #: _____

Medical History

Date of last medical check-up: _____

Have you been treated for any conditions currently or in the past year? ___Yes ___No

Have you ever been hospitalized? ___Yes ___No

If yes, for what?_____

Have you ever had any surgeries? ___Yes ___No

If yes, for what and when were they? _____

_____

Current Medications: _____

_____

Please list any allergies (medication, environmental, food, etc.):_____

_____

Symptoms of allergic reaction:_____

Have you ever been told you require pre-medication prior to dental treatment? ___Yes ___No

Reason for required pre-medication? _____

Do you have a family history of: ____Heart Disease ____Cancer ____Diabetes?

Do you get frequent: ____Headaches ____Earaches ____Ear/nose/throat Infection?

Do you get frequent indigestion or nausea? ___Yes ___No

Do you heal slowly? ___Yes ___No

Do you have a history of excessive bleeding or bruising? ___Yes ___No

Do your ankles, hands, or feet swell? ___Yes ___No

MEDICAL CONSENT FORM

Do you experience any numbness or paralysis in any part of your body? ___Yes ___No

Have you had a sudden change in your weight, appetite, or energy level? ___Yes ___No

Do you have any difficulties swallowing or hearing? ___Yes ___No

Any history of chest pain or shortness of breath? ___Yes ___No

Do you have a history of asthma? ___Yes ___No

Are you pregnant or suspect you may be? ___Yes ___No Due Date:_____

Are you currently breastfeeding? ___Yes ___No

Are you on birth control pill? ___Yes ___No

Are you aware of your bone mineral density? ___Yes ___No

Do you use tobacco products? ___Yes ___No If yes, how many per day? _____

Do you have, or have you had, any of the following conditions: (Please check all that apply)

___HIV/AIDS	___Emphysema	___Herpes	__Radiation Treatment
___Anemia	___Epilepsy/Seizures	___High/Low Blood Pressure	___Chemotherapy
___Angina Pectoris	___Fainting/Dizzy spells	___Hodgkins Disease	___Sickle Cell Disease
___Arthritis/Rheumatism	___Glandular Disorders	___Hyper/Hypo Glycemia	____Scarlet or Rheumatic Fever
___Artificial Joints	___Head/Neck Injuries	___Inflammatory Bowel Disease	___Sinus Trouble
___Blood Disorders	__Heart Disease/Attack	___Jaundice	___Intestine or Ulcer Problems
___Bronchitis	___Heart Murmur	___Kidney Disease	___Stroke
___Cancer	___Heart Pacemaker	___Liver Disease	___Thyroid disease
___Circulation Problems	___Heart Surgery	___Lung Disease	___Tuberculosis
___Congenital Heart Defects	___Heart Rhythm Disorder	___Lupus	___Sexually transmitted infection
___Cortisone/Steroid	___Hepatitis A	___Mental/Nervous Disorder	___Treacher-Collins Syndrome
___Crohn's Disease	___Hepatitis B	___Organ Transplant	
___Diabetes	___Hepatitis C	___Medical Implant	

Do you suffer from dental fear? ___Yes ___No

Patient Certification and Approval

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

Patient/Guardian Signature: _____**Date:** _____

NEW PATIENT INFORMATION & CONSENT

Dental and Hygiene History

1. We would like to take some time get to know you and learn a bit about your dental history.
   Who was your previous dentist/dental office? _____
   _____
   When was your last complete dental exam? _____
   Did you have X-rays taken? _____
2. Is your teeth's appearance (color, shape, alignment) something that you are concerned with? Y/N
   _____
3. How frequently do you have your dental exams? _____
4. Have you previously had a significant amount of dental work completed? Y/N
   If yes, please provide details: _____
   _____
5. What has brought you in today as compared to 3 months ago or 3 months from now?
   _____
   _____
6. Are you aware of any loose teeth? Y/N _____
7. Do you have any TMJ (jaw joint) concerns? Grind/Clench Y/N

   When opening your jaw do you hear ____ a click? ____ a pop? ____ grating noises?

   Do you get headaches or migraines? Y/N
8. Do you breathe through your nose or mouth? Nose Mouth
9. Have you ever been given oral hygiene instructions? ___Brushing ___Flossing____Other
10. Are your teeth sensitive to ; ____ Cold, _____ Hot, ____ Sweets, _____other
11. Do your gums bleed when: ___Brushing ___Flossing ___Spontaneously
12. Do your gums feel tender or swollen? ___Yes ___No
13. Does food catch between your teeth? ___Yes ___No

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is a scale intended to measure daytime sleepiness. This can be helpful in diagnosing sleep disorders such as sleep apnea.

Scale	**Situation**	**Score**
0= Would never doze/sleep	Sitting & Reading	_____
1=Slight chance of dozing/sleeping	Watching TV	_____
2=moderate chance of dozing/sleeping	Sitting in active in a public place	_____
3= High chance of dozing/sleeping	Lying down in the afternoon	_____
	Sitting quietly after lunch (No alcohol)	_____
	Stopped in traffic for a few minutes While driving	_____
	Being a passenger in a vehicle for an Hour or more	_____

PATIENT CERTIFICATION, APPROVAL & CONSENT

I, the undersigned, certify that all medical and dental information provided to the office of Eguren Dentistry is true to my knowledge and I have not omitted any pertinent information. I, the undersigned, consent to the performing of dental and oral surgery procedures **agreed** to be necessary or advisable, including the use of local anaesthetic as indicated. I will assume responsibility for fees associated with these procedures.

Patients (Parent/Guardian) signature _____Date_____