



# Medical History

Childs Name: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone # (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ Sex M  F  Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year

Email \_\_\_\_\_ Mother's Name \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Employer \_\_\_\_\_ Phone (Cell) \_\_\_\_\_

Emergency Contact Number \_\_\_\_\_ Father's Name \_\_\_\_\_

Person Responsible for account \_\_\_\_\_ Employer \_\_\_\_\_ Phone (Cell) \_\_\_\_\_

WHOM MAY WE THANK FOR YOUR REFERRAL: Friend  Name \_\_\_\_\_

Google  Yellow Pages  Newspaper  Flyer  Website  Other  Please specify \_\_\_\_\_

How would you like appointment reminders? Phone  Text  Email

1. Have you been under the care of a medical doctor during the past two years? Yes  No

If yes, for what? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

2. Please list any current medications, vitamins, or supplements: \_\_\_\_\_

3. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes  No

If yes, please list \_\_\_\_\_

4. Has your child been hospitalized in the past five years? Yes  No

5. Indicate which of the following your child has, or presently had:

- |                                      |  |                               |  |                                  |  |
|--------------------------------------|--|-------------------------------|--|----------------------------------|--|
| Heart (Surgery, Disease, Attack)     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Latex Sensitivity.....        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis If Yes Type.....       | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chest Pain.....                      | Yes <input type="checkbox"/> No <input type="checkbox"/> | Stomach Ulcers.....           | Yes <input type="checkbox"/> No <input type="checkbox"/> | Liver Disease.....               | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Congenital Heart Disease.....        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Diabetes If Yes Type.....     | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yellow Jaundice.....             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Murmur.....                    | Yes <input type="checkbox"/> No <input type="checkbox"/> | Thyroid Problems...Hyper/Hypo | Yes <input type="checkbox"/> No <input type="checkbox"/> | Venereal Disease.....            | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| High Blood Pressure.....             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Glaucoma.....                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | A.I.D.S.....                     | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Heart Valve.....          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Emphysema.....                | Yes <input type="checkbox"/> No <input type="checkbox"/> | H.I.V. Positive.....             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Mitral Valve Prolapse.....           | Yes <input type="checkbox"/> No <input type="checkbox"/> | Chronic Cough.....            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Cold Sores / Fever Blisters..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart Pacemaker.....                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tuberculosis.....             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Blood Transfusion.....           | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Rheumatic Fever.....                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Asthma.....                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hemophilia.....                  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Arthritis / Rheumatism.....          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Have you ever needed Premed.  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sickle Cell Disease.....         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cortisone Medicine.....              | Yes <input type="checkbox"/> No <input type="checkbox"/> | Allergies or Hives.....       | Yes <input type="checkbox"/> No <input type="checkbox"/> | Bruise Easily.....               | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Swollen Ankles.....                  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sinus Trouble.....            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Neurological Disorders.....      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Stroke.....                          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Radiation Therapy.....        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Epilepsy or Seizures.....        | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Are you taking Blood Thinners..      | Yes <input type="checkbox"/> No <input type="checkbox"/> | Chemotherapy.....             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Fainting or Dizzy Spells.....    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Joints (hip, knee etc)... | Yes <input type="checkbox"/> No <input type="checkbox"/> | Tumors.....                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Nervous / Anxious.....           | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Kidney Trouble.....                  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Do You Smoke.....             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Psychiatric / Psychological Care | Yes <input type="checkbox"/> No <input type="checkbox"/> |

6. Do you have, or have you had and medical conditions not listed? Yes  No

If Yes, please list \_\_\_\_\_

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any changes in my health or medication.

Patient / Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year

**TURN OVER →**



SIERRA SPRINGS DENTAL

7. Please check yes or no to the following questions:

- Does your child have any dental problems? Yes No If Yes, please explain:
Has your child been to the dentist before? Yes No If Yes, please explain:
Has your child ever had a serious/difficult problem associated with dental work? Yes No If Yes, please explain:
Does your child have a finger or thumb habit? Yes No If Yes, please explain:
Has your child ever had an injury to the face or jaw? Yes No If Yes, please explain:
Are you happy with the appearance of your child's teeth? Yes No If Yes, please explain:

How often does your child brush? How often does your child floss?

TREATMENT CONSENT

I, the under signed, authorize Sierra Springs Dental to perform any necessary dental services and oral surgery that I may need during my diagnosis and treatment with my informed consent. I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. I also understand that any and all dental services are my sole responsibility and that I should make myself aware of any fees associated with my dental care prior to treatment.

Your appointment time will be reserved especially for you. If you are unable to keep your scheduled visit we require a minimum of 2 business days notification. Advance notice allows our office to see other patients who may have been waiting to see us for needed treatment. We thank you in advance for your consideration. A charge of \$50.00 may apply to your account if sufficient notice is not provided.

Patient/Guardian Name Signature of Patient/Guardian Date

INSURANCE

Primary Name of Policy Holder: Date of Birth:
Insurance company:
Insurance Year End: Group/Policy #: ID/Certificate #:
Annual maximum: \$ Annual deductible: \$
Percentage coverage: Basic: % Major: %
Secondary Name of Policy Holder: Date of Birth:
Insurance company:
Insurance Year End: Group/Policy #: ID/Certificate #:
Annual maximum: \$ Annual deductible: \$
Percentage coverage: Basic: % Major: %

INSURANCE (Important)

Direct Billing is a courtesy we offer to our patients and in order to 'Direct Bill' your insurance provider, we require a credit card on file for any outstanding amounts owing after your insurance provider has paid their portion. I hereby agree to the Financial Policy of Sierra Springs Dental as outlined above and authorize Sierra Springs Dental to apply any outstanding balance on my account, not covered by my insurance provider, to the credit card listed below:

Payment Options are as Follows:

VISA Master Card

Card #: Expiry Date: CC Security Code:

Card Holder's Name as appears on card: Authorized Signature:



## **Dental Office Personal Information Consent Form Personal Information & Protection Act**

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 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 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 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 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 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 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 healthcare professionals, such as physicians, if the patient, with their consent, has been referred by us to the other healthcare 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.

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Patient/Guardian Name

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Signature

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Date