

WELCOME

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Name: _____		Date: _____
Address: _____		DOB: _____
City: _____		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Province: _____	Postal Code: _____	
Home Phone: _____	Cell Phone: _____	
Email: _____	Parent/Guardian name: _____	
Who should we thank for referring you? _____		Do you have dental insurance? _____
How did you hear about us? _____		

Responsible Party Information

Name: _____	Spouse: _____
DOB: _____	Spouse's DOB: _____
Address (If different from above) _____	
Employer: _____	Spouse's Employer: _____
Work Phone: _____	Spouse's Work Phone: _____

Dental History

Family Dentist: _____	Date of last Dental visit: _____
Have you seen an orthodontist/Pediatric Dentist before? _____ Name: _____	
<i>Indicate any history of: (Please check all that apply)</i>	
<input type="checkbox"/> Is there pain with chewing, yawning or wide opening?	<input type="checkbox"/> Have there been injuries to the face, or teeth?
<input type="checkbox"/> Have you been informed of missing or extra teeth?	<input type="checkbox"/> Speech/articulation problems
<input type="checkbox"/> Tonsils/adenoids removed	<input type="checkbox"/> Thumb/finger sucking
<input type="checkbox"/> Tongue/swallowing problems	<input type="checkbox"/> Have you/child ever had orthodontic treatment?

Medical History

Family Physician: _____	Date of last check up: _____		
Are you currently under medical care? _____	If yes, explain: _____		
Do you have any drug allergies? _____	If yes, explain: _____		
<i>Indicate any history of: (Please check all that apply)</i>			
<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> asthma	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Nickel/metal allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Heart problems/murmur	<input type="checkbox"/> Headaches
<input type="checkbox"/> Hereditary problems	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Prolonged bleeding	<input type="checkbox"/> other: _____		

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, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses ("Contact Information"). Contact Information is collected and used for:

- to open and update patient files
- to invoice patients for dental services, to process credit card payments, or to collect unpaid accounts
- to process forms for patient reimbursement from 3rd-party health benefit providers & private insurance companies
- to send reminders to patients concerning the need for further dental and/or orthodontic examination or treatment
- to send patients informational material about our orthodontic practice.

Contact Information is disclosed to 3rd party health benefit providers and insurance companies where the patient/ parent has submitted a claim for reimbursement and has asked us to communicate directly with the 3rd party 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 treatment history* ("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 3rd party health benefit providers and insurance companies where patient submitted a claim for reimbursement
- to other dentists/specialists, where we are seeking an opinion, and patient has consented to us obtaining opinion
- to other dentists/specialists if the patient, with their consent, referred to other dentist/specialist for treatment
- to other dentists/specialists where those dentists/specialists asked us, with patient consent, to provide a 2nd 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 2nd opinion or treatment.

If we are 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 and dental specialists 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.

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

I authorize *Drs. Saltaji* and *Altalibi* to perform a clinical examination and to obtain photographic and radiographic documentation.

Name _____ Signature: _____ Date: _____
(Patient/Parent/Guardian)