Cochrane Valley DENTAL

PERSONAL INFORMATION (Please Circle) Dr. Mr. Mrs. Ms. Miss
Name: Last: _____First: _____Middle: _____
Preferred Name: _____ Birthdate (DD/MM/YY): _____/_____/_____
Home Address: _____
City: _____Province: _____Postal Code: _____
Email Address: _____
Phone: Home: _____Work: _____ Mobile: _____
Occupation: _____

IF PATIENT IS A MINOR: Parent/Guardian Information:
Name: Last: _____First: _____Middle: _____
Address (If different from above): _____
City: _____Province: _____Postal Code: _____
Email Address: _____
Phone: Home: _____Work: _____ Mobile: _____

Primary Insurance Information:
Name of Employer: _____
Name of Insurance Company: _____
Group/Policy Number: _____
Name of Secondary Insurance (if any): _____

WHO MAY WE THANK FOR REFFERING YOU TO OUR OFFICE? _____

ELECTRONIC INSURANCE SUBMISSIONS
We extend the courtesy of sending your insurance claims electronically. Due to the Canadian Personal Privacy Act, the details of your dental plan are kept confidential. We are unable to access this information. Please be informed of the details of your dental plan which were provided to you by your employer. It is your responsibility to know these details, including annual plan maximums, frequencies, and all other limitations. We are always happy to help you, should you have any questions.

CANCELLATION POLICY
We look forward to seeing you at your reserved appointment. Should you need to reschedule your appointment, please contact us a minimum of 2 business days prior to your reserved appointment time. If insufficient notice is given, a fee may be charged. Thank you.

I have read and understand the above policies:

_____ _____
Patient/Guardian Signature Date

MEDICAL HISTORY Name: _____

Yes No Are you currently being treated by physician? For what? _____
Date of last medical exam (DD/MM/YY): _____/_____/_____

Yes No Are you taking any medications, nonprescription drugs, or herbal supplements?
If so, please list: _____

Yes No Do you have any allergies? If so, please list: _____

Yes No Have you ever been recommended to take antibiotic prophylaxis before dental treatment?

Yes No Are you taking any blood thinners? If so, please list: _____

Do you have or have you had any of the following:

Yes No	pacemaker	Yes No	hepatitis/liver disease
Yes No	shortness of breath/asthma	Yes No	bleeding disorder
Yes No	lung disease/tuberculosis	Yes No	cancer
Yes No	stomach problems	Yes No	AIDS/HIV infection
Yes No	steroid therapy	Yes No	arthritis
Yes No	radiotherapy/chemotherapy	Yes No	smoke or chew tobacco
Yes No	drug/alcohol dependency	Yes No	psychological disorder
Yes No	artificial heart/heart valve repair	Yes No	diabetes
Yes No	cardiac transplant	Yes No	kidney disease
Yes No	bacterial endocarditis	Yes No	thyroid disease
Yes No	congenital heart disease	Yes No	stroke
Yes No	artificial joint(s)	Yes No	seizures

Yes No Have you ever had treatment for osteoporosis and then taken bisphosphonates?

Yes No Are there any conditions or diseases not listed above that you currently have or have had?
If so, please list:

Yes No **For women only:** Are you currently pregnant or nursing? What is your delivery date? _____

Yes No Are you taking birth control?

DENTAL HISTORY

Yes No Do your gums bleed or are they painful when brushing or flossing?

Yes No Have you ever been treated for gum disease, or have you lost bone around your teeth? Have you ever
Yes No noticed an unpleasant taste or odor in your mouth?

Yes No Is there anyone with a history of periodontal disease in your family? Have you experienced gum
Yes No recession?

Yes No Have you ever had any teeth become loose on their own (without an injury) OR do you have difficulty eating an apple?

Yes No Have you experienced a burning sensation in your mouth?

Yes No Do you have any pain or soreness around your eyes, ears, or other parts of your face? Does your jaw
Yes No click or pop when you yawn or eat?

Yes No Do you have "tension headaches"?

Yes No Do your jaw muscles ever feel tired?

Yes No Are you aware of stiff neck muscles?

Yes No Have you been told you grind your teeth when you sleep

Are you interested in any of the following procedures?

1. In Office Whitening Yes No
2. Clear Braces/Invisalign/SureSmile Aligners Yes No
3. Botox for Wrinkles/Pain Yes No

To the best of my knowledge, the above information is correct. I will inform Cochrane Valley Dental of any changes to my health and/or medications.

_____ _____

Cochrane Valley DENTAL

PERSONAL INFORMATION CONSENT FORM

Patient Name: _____

At Cochrane Valley Dental, we are committed to protecting the privacy of our patient's personal information, and to utilizing all information in a professional and responsible manner. This document summarizes some of the personal information we collect, use, and disclose. In addition to the circumstances described in this document, we also collect, use, and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home address, telephone numbers, and email 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, process credit card payments, and collect unpaid accounts
- To process claims for payment from third party insurance & benefit providers
- To send reminders to patients concerning the need for further dental visits
- To send patients information about our practice, such as newsletters

Contact information is disclosed to third party health benefit providers & insurance companies.

Financial information may be collected in order to make payment arrangements for our services.

We collect patient information regarding health history, family health history, physical condition, and dental treatments (collectively referred to as "Medical Information"). Patient Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.
Patient's Medical Information is disclosed:

- To third party benefit providers and insurance companies
- To other dental specialists
- To other health care providers

I CONSENT TO THE COLLECTION, USE, AND DISCLOSURE OF MY PERSONAL INFORMATION AS OUTLINED ABOVE.

_____ _____

Printed Name Signature