Welcome to Health Plus Dental

Name ______________________________ I like to be called ____________________

Address ____

Phone (Home) ______________________ (Work) ____________ (Cell) ____________

Birth Date __________________ Sex __________ Marital Status ____________________

Occupation ________________ Employer/School ______________________________

Spouse Name ____________________ Spouse's Occupation ________________________

Children (name & age) ____________________________________

____

Special Interests or Hobbies ____________________________________

Whom can we thank for referring you? ______________________________

Please check the statement that **most accurately** describes your dental needs:

- I am interested in being pain free and wish to repair only the most obviously broken teeth.
- I am interested in treatment as long as most of it is covered by dental insurance.
- I want to be presented with all the findings (potential problems) and discuss possible solutions.
- I am interested in a long-term plan which would give me the best chance to keep my teeth for a life in comfort and natural beauty.
- I am interested in exploring ways to improve my smile.

Do you exercise regularly? (What kind and how often) ______________________

Do you do anything to actively manage stress? ______________________

Do you consider yourself health conscious? ______________________

Do you smoke or chew tobacco? (How much?) ______________________

Do you drink alcohol? (How much?) ______________________

Do you enjoy sweets, pop and sugar in coffee or tea? ______________________

Do you make a conscious effort to drink 8 glasses of water a day? ______________________

Do you drink more than one cup of coffee a day? ______________________

Are you following a special diet? ______________________

Is there anything special you would like us to know about you? ______________________

____

In case of an emergency, who should we call?

Name __________________ Phone __________________ Relationship __________________

I understand that all the information I have provided today is correct and to the best of my knowledge. I understand it will be held in strict confidence and only used to improve communications between this office and myself. I also give permission for the doctor and his team to use any records (including photographs) for lecturing/professional presentations as well as promoting dental health to others.

Signed ______________________________ **Date** ____________________

Dr. Nii Ayi Professional Corporation

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 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 number, work telephone number 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
- 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 office, dental materials and services
- 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 patients' 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 the patient has asked us to submit a claim on their behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining a 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 other health care professionals 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.

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

______________________________	___________________________________	______________________________
Print Name	**Signature**	**Relationship (Parent)**

Health Plus Dental – Your Dental History

What has prompted you to seek dental care at this time? ____
Are you currently in pain or discomfort with your teeth, gums or jaw? ____
When was your last dental visit (who was the dentist)? ____
Have you ever had a comprehensive dental exam? ________ When? ____
How often do you see a dental hygienist? ____

Do your gums occasionally bleed when you floss, brush or eat? ____
Are you satisfied with the quality of your breath? ____
Does food get caught between your teeth? ____
Do you have a family history of gum disease? ____
Have you been treated for gum disease? ____
Do you expect to wear dentures someday? ____

I Brush ☐ Never ☐ Occasionally ☐ Weekly ☐ Daily ☐ More than once a day
I Floss ☐ Never ☐ Occasionally ☐ Weekly ☐ Daily ☐ More than once a day

Would you say you have under more than usual pressure in the last 2-3 months? _________________________________
Do you have sleep disturbances? ________________________Do you ever feel tired during the day?_______________
Do you snore? _____________________ Do you experience dry mouth upon wakening? _________________________
Do you clench or grind your teeth? ____
Do your jaws feel tired? ____
Do you have headaches? _____________________ If so how often? ____
Do you chew gum? ____
Have you had problems with keeping your mouth open wide during dental appointments? ______________________
Does your bite feel comfortable? ____
Do you wear a night guard (splint)? ____
Have you ever been treated for TMJ (jaw joint) problems? ____
Have you ever had a locked jaw (open or closed) ____
Does your jaw make any sounds when you open or close your mouth? ______________________________________
Do you have neck, back, hip, knee or ankle problems? ____
Did you have any trauma to your head, neck or jaw (even in early childhood)? ___________________________________
Did you have a whiplash or MVA? ____
Do you have a problem with adjusting to new dental work (filling or crown)? ______________________________________
Do you have earaches? ____
How would you rate your smile on a 1 to 10 scale (10 being most attractive)? _________________________________
What would it take to make it a perfect 10? ____
Are you sensitive to hot, cold, sour or sweet? ____
Did you have orthodontic treatment (braces)? ____
Are you missing some teeth, if so, why? ____
Are you nervous about dental treatment? ____
Is there anything else you would like us to know so we can make your dental visit a stress free experience? ________
____

Name _____________________________ Signed _________________________________ Date ____________________

Health Plus Dental – Confidential Medical Information

Name ______________________ Phone # ______________
Family Doctor ______________________ Phone # ______________
Emergency Contact ______________________ Phone # ______________

HAVE YOU BEEN HOSPITALIZED FOR A SEVERE ILLNESS IN THE LAST 6 MONTHS? ☐ No ☐ Yes

CHECK ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION/MADE YOU

☐ Antibiotics
☐ Aspirin
☐ Codeine
☐ Epinephrine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Metals
☐ Penicillin
☐ Plastic
☐ Sedatives
☐ Sleeping Pills
☐ Sulfa Drugs
☐ Other ____________
☐ NONE

CHECK ANY MEDICATIONS CURRENTLY BEING TAKEN:

☐ Antibiotics
☐ Anticoagulants
☐ Blood Thinners
☐ Blood Pressure (High/Low)
☐ Codeine
☐ Cortisone
☐ Diet Pills
☐ Digestive Aids
☐ Heart Medications
☐ Herbal Products
☐ Insulin, Orinase, etc.
☐ Muscle Relaxants
☐ Nitroglycerine
☐ Pain Medication
☐ Sleeping Pills
☐ Street Drugs
☐ Sulfa Drugs
☐ Tranquilizers
☐ Other ____________
☐ NONE

ARE YOU REQUIRED TO TAKE ANY PREMEDICATION? ☐ No ☐ Yes ________________
ARE THERE ANY MEDICATIONS YOU HAVE BEEN DIRECTED NOT TO TAKE? ________________
CHECK ANY OF THE FOLLOWING CONDITIONS WHICH APPLY TO YOU:

☐ Anemia
☐ Arthritis
☐ Artificial Joint or Prosthetic
☐ Asthma
☐ Bleeding Easily after Cut
☐ Cancer________________
☐ Chemotherapy
☐ Chronic Mouth Dryness
☐ Depression
☐ Digestive Problems/Ulcers
☐ Dizziness
☐ Endocrine Disorders
☐ Epilepsy or Seizures
☐ Headaches
☐ Hearing Impairment
☐ Heart Attack/Angina
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Palpitations Heart Valve Replacement
☐ Hepatitis – Type __________
☐ High Blood Pressure
☐ HIV Infection
☐ Kidney Problems
☐ Liver Problems
☐ Low Blood Pressure
☐ Osteoporosis
☐ Radiation Therapy
☐ Respiration Problems
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sexually Transmitted Disease
☐ Sinus Problem
☐ Smoker
☐ Snoring / Sleep Apnea
☐ Stroke
☐ Tuberculosis
☐ Other ________________
☐ **NONE**

Women Only:
☐ Are you taking Oral Contraceptives?
☐ Are you taking Hormones?
☐ Are you Pregnant?

Due Date: ____________

I understand that I am personally responsible for payment of all dental services rendered. Our practice will on your behalf help prepare patient insurance forms or assist in making collections from the insurance company and will credit any such collections to your account. Dental insurance plays a role in helping patients to acquire dental care; however, it cannot interfere with the proper diagnosis and treatment recommendations. Treatment recommendations are made on your dental health needs, not on what insurance coverage you may or may not have. **I understand that the fees estimated for dental care can only be extended for a period of 3 months** from the date of the patient exam. The undersigned affirm that the information given in the questionnaire is true and accurate to the best of their knowledge. **II authorize the dental staff to perform such dental services as may be necessary and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company for legal documentation.**

I have read the above conditions of treatment and agree to their content. **Date _____/ ______ /_______**

________________________ ________________________ ________________________
Print Name **Signature** **Relationship (Parent)**