HEIGHT: _____

WEIGHT: _____

WEST PEAKS
DENTAL SUITE

Name:	Age:____ Sex:____ Date of Birth (DD/MM/YR) ____/____/____
Address	Postal Code
Preferred Phone Number	Alternate Phone Number
Emergency Contact	Phone number
Primary Dental Insurance	Group/Policy# ID#
Secondary Dental Insurance	Group/Policy# ID#
Secondary Policy Holders Name	Date of Birth (DD/MM/YR) ____/____/____
How did you hear about our office?	

Please let us know how you would like us to communicate by checking the box and providing contact information.

☐ Text message (Please provide if other than preferred number):_____

☐ Email:_____

☐ Phone call or voice message at preferred number (Please provide if different than preferred number): _____

		Yes	No
Personal Dental History			
1.	Are you fearful of dental treatment?	☐	☐
2.	*Have you had an unfavorable dental experience?*	☐	☐
3.	*Have you ever had complications following dental treatment?*	☐	☐
4.	*Do you have trouble getting numb or have had reactions to dental anesthetics?*	☐	☐
5.	*Have you had teeth removed in the past?*	☐	☐
Smile characteristics			
6.	*Is there anything about the appearance of your teeth that you would like changed?*	☐	☐
7.	*Have you ever bleached your teeth?*	☐	☐
8.	*Are you self conscious about your teeth or smile?*	☐	☐
9.	*Have you been disappointed with the appearance of past dental work?*	☐	☐
Bite and Jaw Joint			
10.	*Do you or would you have difficulty chewing gum?*	☐	☐
11.	*Do you or would you experience difficulties chewing bagels or other hard foods?*	☐	☐
12.	*Have your teeth become shorter, thinner or worn over the last 5 years?*	☐	☐
13.	*Have your teeth become crowded or developed spaces between them in the last 5 years?*	☐	☐
14.	*Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?*	☐	☐
15.	*Do you have troubles sleeping or wake up with an awareness of your teeth?*	☐	☐
16.	*Do you or have you experienced problems with your jaw joint? (pain, clicking, popping, sounds)*	☐	☐
17.	*Has your jaw ever locked open or shut?*	☐	☐
18.	*Have you ever worn a bite appliance or night guard?*	☐	☐
19.	*Do you experience frequent tension headaches or sore teeth?*	☐	☐
Tooth Structure			
20.	*Have you had a cavity within the last two years?*	☐	☐
21.	*Do you experience a dry mouth?*	☐	☐
22.	*Are your teeth sensitive to hot, cold or sweets?*	☐	☐
23.	*Have you ever had a cracked tooth and/or filling, toothache or broken tooth?*	☐	☐
24.	*Do you avoid brushing or eating in any particular part of the mouth?*	☐	☐
Gum and Bone			
25.	*Have you ever been diagnosed with or treated for periodontal (gum) disease?*	☐	☐
26.	*Have you experienced gum recession?*	☐	☐
27.	*Do your gums bleed when you floss or brush?*	☐	☐
28.	*Is there a history of anyone in your immediate family with early tooth loss or periodontal disease?*	☐	☐
29.	*Are your teeth becoming loose?*	☐	☐
30.	*Have you ever noticed or experienced an unpleasant odor or taste in your mouth?*	☐	☐

WEST PEAKS DENTAL SUITE

Patient Name: _____

1. When was your last medical check-up? _____ Name of Physician? _____
2. Have you experienced excessive weight gain or loss recently? Yes No
3. Women: Are you currently pregnant or breast feeding? Yes No
4. Have you been hospitalized previously? Reason _____
5. Have you ever been diagnosed or treated for any of the following conditions?

Heart Problems

	Yes	No
1. Heart failure	☐	☐
2. Heart disease	☐	☐
3. Heart Murmur	☐	☐
4. Angina pectoralis or chest pain	☐	☐
5. Heart attack	☐	☐
6. High blood pressure	☐	☐
7. Low blood pressure	☐	☐
8. Rheumatic fever	☐	☐
9. Mitral valve prolapse	☐	☐
10. Arrhythmia	☐	☐
11. Stroke	☐	☐
12. Congenital heart defect	☐	☐

Blood Disorders

13. Hemophilia	☐	☐
14. Anemia	☐	☐
15. Leukemia	☐	☐
16. Prolonged bleeding	☐	☐

Breathing & Lung Problems

17. Hay fever	☐	☐
18. Sinus problems	☐	☐
19. Tuberculosis	☐	☐
20. Asthma	☐	☐
21. Chronic Obstructive Pulmonary Disease	☐	☐
22. Emphysema	☐	☐

Digestive Problems

23. Crohn's disease	☐	☐
24. Ulcerative colitis	☐	☐
25. Celiac disease	☐	☐
26. Kidney disease	☐	☐
27. G.E.R.D. (Gastro-esophageal reflux disease)	☐	☐
28. Liver disease	☐	☐
29. Stomach or duodenal ulcers	☐	☐

Metabolic Disorders

30. High cholesterol	☐	☐
31. Diabetes	☐	☐
32. Hyperthyroidism	☐	☐
33. Osteoporosis	☐	☐
34. Hormone deficiency	☐	☐
35. Addison's disease	☐	☐
36. Cushing's disease	☐	☐

Viral Ailments

37. Hepatitis A B C ____	☐	☐
38. AIDS/HIV	☐	☐
39. Cold sores	☐	☐

Other Conditions

40. Epilepsy	☐	☐
41. Malignant hyperthermia	☐	☐
42. Arthritis	☐	☐
43. Glaucoma	☐	☐
44. Frequent headaches	☐	☐
45. Fibromyalgia	☐	☐
46. Bulimia/Anorexia	☐	☐
47. Cancer	☐	☐
48. Substance abuse	☐	☐
49. Current smoker	☐	☐
50. Hearing impairment	☐	☐
51. Psychiatric condition	☐	☐

6. Have you ever experienced a reaction to, or are aware of an existing allergy to any of the following?

	Yes	No
a. Metals (gold, silver, nickel) _____	☐	☐
b. Local anesthetics or general anesthetics ____	☐	☐
c. Latex _____	☐	☐
d. Aspirin, acetaminophen, ibuprophen _____	☐	☐
e. Tetracycline _____	☐	☐
f. Fluoride _____	☐	☐
g. Penicillin _____	☐	☐
h. Codeine _____	☐	☐
i. Sulfa based medications _____	☐	☐
j. Known allergy to other medications: (please list) _____	☐	☐

7. Are you currently taking any of the following medications?

	Yes	No
a. Bisphosphonates (Fosamax, Didrocal, Actonel, Aclasta or Fosavance) _____	☐	☐
b. High blood pressure medication _____	☐	☐
c. Antidepressant medications _____	☐	☐
d. Steroid or corticosteroids (Including prednisone)	☐	☐
e. Nitroglycerine _____	☐	☐
f. Dilantin or anticonvulsants _____	☐	☐
g. Blood thinner (Plavix, Heparin, Coumadin, Warfarin)	☐	☐
h. Birth control pill _____	☐	☐
i. Insulin, Metformin, Tolbutamide _____	☐	☐
j. Tranquilizers _____	☐	☐
k. Antibiotics _____	☐	☐
i. Please List Medications: _____ _____	☐	☐

8. Have you or are you currently undergoing any of the following medical procedures?

	Yes	No
a. Artificial joint replacement _____	☐	☐
b. Artificial heart valve placement _____	☐	☐
c. Organ transplant _____	☐	☐
d. Chemotherapy for cancer _____	☐	☐
e. Radiation therapy for cancer _____	☐	☐
f. Blood transfusion _____	☐	☐
g. Dialysis _____	☐	☐
h. Pacemaker or defibrillator _____	☐	☐

11. Are there any medical conditions not listed here that you have been diagnosed or treated for?

_____

To the best of my knowledge, all of the information provided above is true and correct. If I ever have any change in my health, abnormal laboratory test, or if my medications or medical status change, I will inform the dentist at my next dental visit.

Date	Name (Patient, Parent or Legal Guardian)	Signature (Patient, Parent or Legal Guardian)
Date	Reviewed By (Office Use Only)	Reviewers Signature (Office Use Only)

WEST PEAKS
DENTAL SUITE

West Peaks Dental Suite Personal Information Consent Form

At West Peaks Dental we are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. We are HIPAA and PIPA compliant.

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, 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 and/or treatment.

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:
- 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 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 the 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.

Date	Print Name	Signature