Dr. Martin Warren
Family & General Dentistry
#810, 10080 Jasper Avenue
Edmonton, AB T5J 1V9
(780) 422-6117

PERSONAL HEALTH RECORD

Date_____ Patient's Name_____ Birthday_____

Age_____ Sex____ Address_____ City_____

Province_____ Postal Code_____ Home Phone_____

Business Phone_____ Alberta Health Care Number_____

Doctor's Name & Phone Number_____

Referred By_____

Emergency Contact Name & Phone Number_____

Occupation_____

Employer Name & Address_____

Dental Benefits Company_____ Certificate #_____

Group #_____Name of Policy Holder_____ Previous Dentist_____

Email Address_____

MEDICAL HISTORY

1.	Are you currently under the care of a physician?	Yes	No
2.	Are you taking any medication of any kind?	Yes	No
	If yes, what kind?_____		
3.	Have you taken Cortisone or other steroids in the past 12 months?	Yes	No
4.	Do you have reactions or allergies to drugs or medications?	Yes	No
5.	Have you had a reaction to dental or general anesthetic?	Yes	No
6.	Have you ever has any operations or surgery?	Yes	No
	Describe the problem and any complications.		
	_____		
7.	WOMEN: Are you pregnant?	Yes	No

8. Height _____ Weight _____

Please check any condition that you have, or have had in the past. It is important that you current medical status be known many disorders require alterations in the provision of dental treatment.

Cardiovascular
Heat failure
Heart disease/attack
Angina pectoris/chest pain
Pain
High blood pressure
Heart murmur
Mitral valve proplapse
Rheumatic fever
Congenital heart defect or lesion
Artificial heart valve
Arrhythmias
Heart pacemaker or defibrillator
Heart surgery/transplant
Other heart problems
Stroke
Aneurysm

Hematologic
Blood transfusion
Anemia
Hemophilia
Leukemia
Sickle cell (anemia) disease
Tendency to bleed longer than normal

Neural and Sensory
Eye pain
Vision problems
Glaucoma
Earaches, ringing in ears
Hearing loss
Severe headaches
Fainting/dizzy spells
Epilepsy/seizures/ convulsions
Nervousness

Gastriontestinal
Stomach/intestinal ulcers
Gastritis
Colitis
Persistent diarrhea
Hepatitis
Liver disease
Yellow jaundice
Cirrhosis

Respiratory
Hay fever
Sinus trouble
Allergies/hives
Asthma
Chronic cough
Emphysema
Tuberculosis (TB)
Breathing difficulties

Dermal Mucocutaneous Musculoskeletal
Allergy to latex (rubber)
Skin rash
Dark mole(s) recent changes in appearance
Night sweats
Sore muscles
Stiff joints
Arthritis
Artificial joint
Fever blister/cold sore
Mouth ulcers/canker sores
Colored or discoloured areas in mouth

Endocrine
Diabetes
Thyroid Disease

Urinary/Sexually Transmitted
Urinate frequently
Kidney, bladder problem
Sexually transmitted disease (syphilis, gonorrhea, Chlamydia
or Genital Herpes)
HIV positive

Other Conditions
Frequent sore throat
Enlarged lymph node/gland
Use Tobacco
Drug/alcohol addiction (recovering or current)
Tumor/cancer
X-ray/cobalt treatment
Chemotherapy
Disease or problem not listed
_____
_____
_____
_____

DENTAL HISTORY:

1. Are you having dental pain? Yes No
2. Do you think you have gum problems? Yes No
3. Do you notice popping, clicking, soreness of the jaws or in front of the ears? Yes No
4. Do you brush daily? Yes No How many times in a day? _____
5. Do you floss daily? Yes No How many times in a day? _____
6. a) When was your last dental visit? _____
   b) What was done? _____
   c) When were your last dental x-rays taken? _____
7. Have you ever had dental freezing (local anesthetic) problems? Yes No
8. Are you anxious about dental treatment? Yes No

PLEASE READ THE FOLLOWING STATEMENT AND SIGN WHERE INDICATED:

I have answered the above questions to the best of my ability and have disclosed my Medical Condition. I give consent to Dr. Warren to provide those services which are necessary and **have been discussed fully with me prior to treatment**. These procedures may include the use of local anesthesia and sedative medication. I understand that I am financially responsible to the Dentist for the entire cost of treatment regardless of Dental Benefits coverage.

Signature:

SMILE QUESTIONNAIRE (OPTIONAL):

If you are interested in improving your smile, then please complete this smile questionnaire. If you answer "yes" to any of these questions, it's likely you can benefit from cosmetic dentistry.
There are many types of cosmetic procedures and they may differ in cost, care and durability. A thorough dental evaluation in our office can help you decide which type of aesthetic treatment is best for you.

Yes	No	Are you happy with the color (whiteness) of your teeth?
Yes	No	Do you have any stained or discolored teeth or fillings?
Yes	No	Do any of your teeth have uneven shapes due to chips, fractures or rough edges?
Yes	No	Are any of your teeth crowded, overlapping or crooked?
Yes	No	Do you have any gaps between your teeth or are you missing any teeth?
Yes	No	Are your teeth uneven in length?

FOR DR. WARREN'S OFFICE STAFF USE ONLY:

Medical History Evaluation Update:

Dental Office Personal Information Consent Form

We are committed to protecting the privacy of out 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 (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 information material about out dental practice.

Contact information is disclosed to third party health benefit providers and insurance companies where the patient ahs 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.

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 specialist where those dentist 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 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.

_____	_____	_____
Date	Print Name	Signature