**Medicine Hat Denture Clinic**

**106 3030 13th Ave. S.E.**

**Office Use Only**

**Medical History Alert Numbers**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History Alert Numbers**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicine Hat, Alberta, T1B 1E3**

|  |
| --- |
| **Personal Information: Please Print or place an “X” into the appropriate box(es)** |
|  |  |
|  |  |
| Name: |       Date of Birth:  |
|  |  |  |  |  |
| Home Address |  |  |  Postal Code: |  |
|  |  |  |  |  |
| City: |  | Province |  Home Phone : |  |
|  |
| Employment: |        | Cell / Work Phone:  |       |
|  |
| Physician: |  | Dentist:  |
|  |
| Referred By: |  |
|  |  |  |  |  |
| Legal Guardian:  |  | Contact # |
|  |
| Emergency | Name: |  Phone#: |
|  |  |  |  |  |
| Relationship  |  |  Phone #: |  |
|  |  |       |  |  |
|  |  |  |  |
|  |  |  |  |  |
| Your Living Environment | Do you require medical devices or equipment such as oxygen, walker, cane, etc? ……… | [ ]  Yes |  | [ ]  No |
|  |  |  |  |  |
|  | If yes, please describe: |
|  |  |  |  |  |
|  |  |
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|  |  |  |  |  |
| Individual Responsible For Account: | [ ]  Patient | [ ]  Guardian |  |
|  | [ ]  Insurance & Patient | [ ]  Insurance & Guardian |
|  |

|  |
| --- |
|  |
| **Medical Health History**  |
|  |
| 1. Are you currently under the care of a physician? ……………………………………………….….
 |
|  | If yes, what for? |       |
|  |
| 1. Have you ever had any serious illness or been hospitalized? ……………………………............
 |
|  | If yes, what for? |       |
|  |
|  |
| 1. Please place an “X” into the appropriate box for the listed health issues. Indicate yes if you have had the condition even if you do not currently have that condition.
 |
| **YES** | **NO** |  | **YES** | **NO** |  |
|  |  |  |  |  |  |
| [ ]  | [ ]  | HIV / AIDS:      |  |  |  |
| **[ ]**  | [ ]  | Environmental Allergies. Specify:      | [ ]  | [ ]  | Immune Deficiency:      |
| **[ ]**  | [ ]  | Food Allergies. Specify:      | [ ]  | [ ]  | Herpes Virus (cold sores) :      |
| **[ ]**  | [ ]  | Latex Allergy:       |  |  |  |
| **[ ]**  | [ ]  | Other Allergies. Specify:      | [ ]  | [ ]  | Kidney Disease:      |
|  |  |  | [ ]  | [ ]  | Kidney Stones:      |
| **[ ]**  | [ ]  | Asthma:      |  |  |  |
| **[ ]**  | [ ]  | Chronic Obstructive Pulmonary Disease:      | [ ]  | [ ]  | Heart Attack:      |
| **[ ]**  | [ ]  | Difficulty breathing:      | [ ]  | [ ]  | Heart Disease:      |
| **[ ]**  | [ ]  | Emphysema:      | [ ]  | [ ]  | Rheumatic Fever:      |
| **[ ]**  | [ ]  | Tuberculosis:      | [ ]  | [ ]  | Heart Murmur:      |
|  |  |  | [ ]  | [ ]  | Heart Surgery:      |
| **[ ]**  | [ ]  | Hepatitis A:      |  | [ ]  | [ ]  | Artificial Heart Valve:      |
| **[ ]**  | [ ]  | Hepatitis B:      | [ ]  | [ ]  | Pacemaker:      |
| **[ ]**  | [ ]  | Hepatitis C:      | [ ]  | [ ]  | Angina pectoris:      |
| **[ ]**  | [ ]  | Other Liver Disease: Specify:       |  |  |  |
|  |  |  | [ ]  | [ ]  | Cholesterol problems:      |
| **[ ]**  | [ ]  | Arthritis:      | [ ]  | [ ]  | High Blood Pressure:      |
| **[ ]**  | [ ]  | Artificial Joint replacement- Specify:      | [ ]  | [ ]  | Low Blood Pressure:      |
|  |  |       | [ ]  | [ ]  | Bleeding Disorder/Haemophilia:       |
|  |  |  | [ ]  | [ ]  | Stroke:      |
| **[ ]**  | [ ]  | Cancer. Specify:      |  |  |  |
| **[ ]**  | [ ]  | Chemotherapy/Radiation therapy:      | [ ]  | [ ]  | Nervousness/Psychiatric condition:      |
|  |  |  |  |  |  |
| **[ ]**  | [ ]  | Diabetes Type 1:      | [ ]  | [ ]  | Organ Transplant : If yes, specify:       |
| **[ ]**  | [ ]  | Diabetes Type 2:      |  |  |       |
| **[ ]**  | [ ]  | Eating disorder. If yes: [ ] anorexia [ ] bulimia | [ ]  | [ ]  | Thyroid Disease. If yes: [ ]  Hyper [ ] Hypo |
|  |  |  |  |  |  |
| **[ ]**  | [ ]  | Epilepsy or Seizures:      | [ ]  | [ ]  | Surgeries- specify:       |
| **[ ]**  | [ ]  | Dizziness/fainting:      |  |  |        |
|  | **[ ]**  | Other. Specify:       |
|  |
|  |
| 1. Have you ever experienced a bad reaction to any of the following medications:
 |
| **Medication** | **Yes**  | **No** | **Never Used** | **Medication** | **Yes** |
| Anaesthetic | [ ]  | [ ]  | [ ]  | Penicillin | [ ]  |
| Barbiturates (sleeping pills) | [ ]  | [ ]  | [ ]  | Sulphonamides (sulpha) | [ ]  |
| Codeine | [ ]  | [ ]  | [ ]  | Tranquilizers | [ ]  |
| Cortisone (steroids) | [ ]  | [ ]  | [ ]  |  |  |
| Other- please list:  | [ ]  |       |
| 1. Are you taking any medications, over the counter medications or herbal remedies? …………..
 |
|  | If yes, what? |       |
|  |  |       |
|  | If yes, what for? |       |
|  |  |       |
|  |

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| --- | --- |
|  |  |
| **Dental Health History Please place an “X” into the appropriate box or provide your written response** |
|  |
| 1. When was your last dental visit? ………
 |  |
|  |
| 1. What procedures did you have done at that visit? …
 |       |
|  |
| 1. Have you had any complications following a dental procedure? ................................................
 | [ ]  Yes | [ ]  No |
| If yes, please explain |       |
|  |
| 1. Have you had dental x-rays done in the last two (2) years? …………..……………………….......
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have any dental work ongoing at this time? ……………………………..………..………...
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have any outstanding dental work to be done? …………………………………..………...
 | [ ]  Yes | [ ]  No |
| If yes, what procedures  |       |
|  |
| 1. Do you have any sensitive teeth (if applicable)?
 | [ ]  Yes | [ ]  No |
| 1. Do your gums bleed (if applicable)? ……………………………………………………………….....
 |
| 1. Do you normally have a bad taste/odour in your mouth?..……………………………………………
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have any pain in your jaw joint? ……………………………………………………..............
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you clench or grind your teeth? .............................................................................................
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have dental implants? ………………………………………...............................................
 | [ ]  Yes | [ ]  No |
|  |
| 1. Have you ever had an accident or had trauma/injury to your neck or jaws? ...............................
 | [ ]  Yes | [ ]  No |
|  |       |  |
| 1. Do you have any pain or numbness in your head, neck or jaws? …….…………………………...
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have any sore spots or anomalies in your mouth? .……………………………................
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have any habits which affect your mouth such as mouth breathing, chewing objects, chewing nails, etc? ……………………………………………………………………………………...
 | [ ]  Yes | [ ]  No |
|  |  |  |
|  |
| 1. Have you been diagnosed with Sleep Apnea? ………………..……….……………………….....
 | [ ]  Yes | [ ]  No |
|  |  |  |
|  |
| 1. Do you have any other dental health issues which have not been addressed above? …………
 | [ ]  Yes | [ ]  No |
|  |
|  |
|  |
| **Complete the following questions only if you have some or all of your natural teeth** |
|  |
| 1. How often do you brush your teeth?
 | [ ]  Daily | [ ]  Weekly | [ ]  Other (specify)  |       |
|  |
| 1. How often do you floss your teeth?
 | [ ]  Daily | [ ]  Weekly | [ ]  Other (specify)  |       |
|  |
| 1. How often do you see a Hygienist?
 | [ ]  Yearly | [ ]  Bi-Yearly | [ ]  Other (specify)  |       |

|  |
| --- |
| **Complete the following questions only if you have a denture or dentures** |
| 1. What type of dentures do you have? (complete or partial)
 | Complete: | Upper: [ ]  | Lower: [ ]  |
|  | Partial: | Upper: [ ]  | Lower: [ ]  |
|  |
| 1. When were your dentures made?….…………….............
 | Upper:       (year) | Lower:       (year) |
|  |
| 1. Who provided you with the dentures? ……..………………….
 | Upper: |       |
|  [ ]  Unknown/Prefer not to say | Lower: |       |
|  |
| 1. Do your gums get sores under your denture(s)? …………...
 | Upper [ ]  Yes [ ]  No | Lower [ ]  Yes [ ]  No |
|  | If yes, how often | [ ]  Daily | [ ]  Weekly | [ ]  Occasionally | [ ]  Other (Specify): |       |
|  |
| 1. Do you brush your gums under your denture(s)? …….....…..
 | Upper [ ]  Yes [ ]  No | Lower [ ]  Yes [ ]  No |
|  |
| 1. Do you wear your denture(s) at night (if applicable)? …...…..
 | Upper [ ]  Yes [ ]  No | Lower [ ]  Yes [ ]  No |
|  |
| 1. How many dentures have you had (if applicable)? …............
 | Upper:        | Lower:       |
|  |
| 1. Are you happy with the appearance of your dentures? ……………………………………………..
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you have problems eating any particular types of food? ……………………………………..
 | [ ]  Yes | [ ]  No |
|  |
| 1. Do you use denture adhesives? ……………………………………………………………………….
 | [ ]  Yes | [ ]  No |
|  |
| 1. Have the benefits of dental implants been discussed with you? ………………………………...
 | [ ]  Yes | [ ]  No |
|  |

***“I the undersigned, hereby certify that all of the medical and dental information provided on this form to be true to the best of my knowledge and that I have not knowingly omitted any information. I also consent to my family physician/family dentist being contacted, if necessary, to obtain further information or clarification of medical/dental conditions as is necessary for my Denturist treatment****.”*

*Dated this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature

|  |
| --- |
| **Office Use Only****Notes related to Responses on the Dental History** |
| QuestionNumber | Notes |
|  |  |
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**Personal Information Protection Act Consent Form**

**Medicine Hat Denture Clinic**

In our office, we are dedicated to ensuring the protection of our patients’ personal information and insuring that this information is used only in a professional manner. The following indicates some of the information that is collected, why we collect it, and when we may disclose your personal information. We collect, use and disclose your personal information where permitted or required by law.

**Contact Information**

We collect contact information from our patients such as full name, home address, home telephone number(s), home email address, work address, work telephone number(s), work email address, and cellular phone number. This information is considered as Contact Information and it is collected for a variety of purposes including the following:

* To open and update a patient file;
* To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts;
* To process claims for payment or reimbursement from a third-party health benefit provider or insurance company\*;
* To send correspondence to our patients regarding need for further examination or treatments; and
* To send correspondence to our patients regarding our clinic and practice.\* Contact information is/may be disclosed to a third party health benefit provider or insurance company when submitting a claim on the patients’ behalf, for payment or reimbursement of all or part of the cost of the treatment provided, or when a patient has requested a preauthorization of a proposed treatment.

**Medical/Dental History**

We collect from our patients, information about their health history, family health history, physical and mental condition, their dental health history, and family dental health history. This Medical/Dental information is collected for a variety of purposes and may be used in part to assist us in diagnosing dental conditions and providing appropriate treatment for you, and may be disclosed for the following purposes:

* To a third-party health benefit provider or insurance company, in the submission of a claim on behalf of the patient, for reimbursement or payment of all or part of the cost of the treatment ;
* To a third-party health benefit provider or insurance company on behalf of the patient, in the submission of a preauthorization of treatment;
* To other health/dental providers where, upon your consent, we are seeking a second opinion;
* To other health/dental providers where, upon your consent, we have referred you to for additional\alternative treatment;

**Financial Information**

We collect information related to financial matters for facilitation of payment of your treatment(s).

**Future Use**

If consideration to sell this practice or a portion of this practice ever occurs, any qualified potential purchasers may be granted access as part of due diligence process to patient information, in order to verify information related to the sale. If this ever occurs, we will take necessary steps to ensure that the prospective purchaser protects any personal information, as we have done.

**Regulatory**

The College of Alberta Denturists regulates all Denturists in the Province of Alberta and as part of their regulatory function, may inspect our records and interview our staff in the process of their duties.

**Consent**

I hereby authorize and consent to the collection, use and disclosure of personal information concerning myself with regards to the above purposes, dated at the City/Town of Medicine Hat in the Province of Alberta, on the       day of      \_\_\_\_\_\_\_\_\_\_\_\_\_\_, 202\_\_\_.

 (Patient/Guardian Name) (Patient /Guardian Signature)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVID-19 Pre-Screening via Telephone**

* Do you currently have a fever? Yes \_\_\_\_ No \_\_\_\_
* Do you currently have a cough? Yes \_\_\_\_ No \_\_\_\_
* Do you have difficulty breathing? Yes \_\_\_\_ No \_\_\_\_
* Have you traveled outside of the

Country in the last 14 days? Yes \_\_\_\_ No \_\_\_\_

* In the last 14 days have you come into

Contact with anyone suspected or

Confirmed with Covid-19 Yes \_\_\_\_ No\_\_\_\_

* In the last 14 days have you been in

Contact with anyone ill in any capacity? Yes \_\_\_\_ No \_\_\_\_

**If you answer yes to any of the above question ask they stay home and complete Alberta’s online COVID-19 self-assessment.**

Appointment Booked Yes \_\_\_\_ No \_\_\_\_

Date: \_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_

**APPOINTMENT PRE-SCREENING**

* Do you currently have a fever? Yes \_\_\_\_ No \_\_\_\_
* Do you currently have a cough? Yes \_\_\_\_ No \_\_\_\_
* Do you have difficulty breathing? Yes \_\_\_\_ No \_\_\_\_
* Have you traveled outside of the

Country in the last 14 days? Yes \_\_\_\_ No \_\_\_\_

* In the last 14 days have you come into

Contact with anyone suspected or

Confirmed with Covid-19 Yes \_\_\_\_ No\_\_\_\_

* In the last 14 days have you been in

Contact with anyone ill in any capacity? Yes \_\_\_\_ No \_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_ Time in: \_\_\_\_ Time out:\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_