Souris Family Dental

NEW PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY/PROVINCE _____**POSTAL CODE**_____

EMAIL ADDRESS _____

HOME PHONE _____ **WORK PHONE**_____

CELL PHONE _____

DATE OF BIRTH: DAY _____ **MONTH** _____ **YEAR** _____

MALE ☐ **FEMALE** ☐

HEALTH CARD NUMBER _____

MEDICAL DOCTOR'S NAME _____

CONTACT FOR CHILDREN UNDER 18:

FATHER WORK # _____ *FATHER CELL #*_____

*MOTHER WORK#*_____ *MOTHER CELL#* _____

NAMES OF IMMEDIATE FAMILY MEMBERS SEEN IN OUR OFFICE: _____

_____

This is the certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anaesthesia, inhalation, or intravenous sedation as indicated and I will assume responsibility for fees associated with those procedures.

X _____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**

DENTAL INSURANCE INFORMATION

PRIMARY PLAN - **POLICY HOLDER** _____

POLICY HOLDER D.O.B._____

EMPLOYER _____

INSURANCE COMPANY _____

GROUP/PLAN # _____ **ID #**_____

SECONDARY PLAN - **POLICY HOLDER** _____

POLICY HOLDER D.O.B. _____

EMPLOYER _____

INSURANCE COMPANY _____

GROUP/PLAN # _____ **ID #** _____

I authorize release to my Dental Benefits Plan Administrator and CDA information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revokes the same.

X _____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN **DATE**

New Patient

PRIVACY, DISCLOSURE, & CONSENT

TO: Souris Dental and Souris Health Services

Information for our Patients

At Souris Dental, all professional dental services are performed by licensed members of the College of Dental Surgeons of Saskatchewan ("Dental Professionals"), and all institutional health care services are performed independently by Souris Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Souris Dental and Souris Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Souris Health Services.

Privacy Act and Consent to Treatment

By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Souris Dental; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Souris Dental to provide the services you are requesting.

Acknowledgement regarding Information Provided

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical – dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office**. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among Souris Dental, Souris Health Services, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Souris Dental and Souris Health Services in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that the Souris Dental and Souris Health Services are relying upon the information which I have provided being accurate and complete.

_____ _____ _____

Print Name of ☐Patient ☐Parent ☐ Guardian Signature of ☐Patient ☐Parent ☐ Guardian Date

_____ _____

Reviewed by Souris Dental Date

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ⊙ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ⊙ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ⊙ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ⊙ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ⊙ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ⊙ No	If yes
Are you on a special diet?	○ Yes ⊙ No	
Do you use tobacco?	○ Yes ⊙ No	
Do you use controlled substances?	○ Yes ⊙ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ⊙ No	Cortisone Medicine ○ Yes ⊙ No	Hemophilia ○ Yes ⊙ No	Radiation Treatments ○ Yes ⊙ No
Alzheimer's Disease ○ Yes ⊙ No	Diabetes ○ Yes ⊙ No	Hepatitis A ○ Yes ⊙ No	Recent Weight Loss ○ Yes ⊙ No
Anaphylaxis ○ Yes ⊙ No	Drug Addiction ○ Yes ⊙ No	Hepatitis B or C ○ Yes ⊙ No	Renal Dialysis ○ Yes ⊙ No
Anemia ○ Yes ⊙ No	Easily Winded ○ Yes ⊙ No	Herpes ○ Yes ⊙ No	Rheumatic Fever ○ Yes ⊙ No
Angina ○ Yes ⊙ No	Emphysema ○ Yes ⊙ No	High Blood Pressure ○ Yes ⊙ No	Rheumatism ○ Yes ⊙ No
Arthritis/Gout ○ Yes ⊙ No	Epilepsy or Seizures ○ Yes ⊙ No	High Cholesterol ○ Yes ⊙ No	Scarlet Fever ○ Yes ⊙ No
Artificial Heart Valve ○ Yes ⊙ No	Excessive Bleeding ○ Yes ⊙ No	Hives or Rash ○ Yes ⊙ No	Shingles ○ Yes ⊙ No
Artificial Joint ○ Yes ⊙ No	Excessive Thirst ○ Yes ⊙ No	Hypoglycemia ○ Yes ⊙ No	Sickle Cell Disease ○ Yes ⊙ No
Asthma ○ Yes ⊙ No	Fainting Spells/Dizziness ○ Yes ⊙ No	Irregular Heartbeat ○ Yes ⊙ No	Sinus Trouble ○ Yes ⊙ No
Blood Disease ○ Yes ⊙ No	Frequent Cough ○ Yes ⊙ No	Kidney Problems ○ Yes ⊙ No	Spina Bifida ○ Yes ⊙ No
Blood Transfusion ○ Yes ⊙ No	Frequent Diarrhea ○ Yes ⊙ No	Leukemia ○ Yes ⊙ No	Stomach/Intestinal Disease ○ Yes ⊙ No
Breathing Problems ○ Yes ⊙ No	Frequent Headaches ○ Yes ⊙ No	Liver Disease ○ Yes ⊙ No	Stroke ○ Yes ⊙ No
Bruise Easily ○ Yes ⊙ No	Genital Herpes ○ Yes ⊙ No	Low Blood Pressure ○ Yes ⊙ No	Swelling of Limbs ○ Yes ⊙ No
Cancer ○ Yes ⊙ No	Glaucoma ○ Yes ⊙ No	Lung Disease ○ Yes ⊙ No	Thyroid Disease ○ Yes ⊙ No
Chemotherapy ○ Yes ⊙ No	Hay Fever ○ Yes ⊙ No	Mitral Valve Prolapse ○ Yes ⊙ No	Tonsillitis ○ Yes ⊙ No
Chest Pains ○ Yes ⊙ No	Heart Attack/Failure ○ Yes ⊙ No	Osteoporosis ○ Yes ⊙ No	Tuberculosis ○ Yes ⊙ No
Cold Sores/Fever Blisters ○ Yes ⊙ No	Heart Murmur ○ Yes ⊙ No	Pain in Jaw Joints ○ Yes ⊙ No	Tumors or Growths ○ Yes ⊙ No
Congenital Heart Disorder ○ Yes ⊙ No	Heart Pacemaker ○ Yes ⊙ No	Parathyroid Disease ○ Yes ⊙ No	Ulcers ○ Yes ⊙ No
Convulsions ○ Yes ⊙ No	Heart Trouble/Disease ○ Yes ⊙ No	Psychiatric Care ○ Yes ⊙ No	Venereal Disease ○ Yes ⊙ No
			Yellow Jaundice ○ Yes ⊙ No

Have you ever had any serious illness not listed above? ○ Yes ⊙ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____