West Campus Dental – Dr. John Schmidt

Personal

Last Name: ……..

Given Name: ……..

Address: ……..

City: …… Postal Code: ……..

Phone: Home#: ……. Bus#: ……..

Date of Birth: ……..

Marital Status: ……..

Occupation: ……..

Employer: ……..

Your Spouse's Name: ……..

Occupation: ……..

Employer: ……..

Business Phone: ……..

Parents Name: ……Bus#: ……..

Whom may we thank for referring you to this office:

……

Dental

How long has it been since your last dental visit?

……

Name of previous dentist:

……

Reason for changing dentist?

……

I understand that I will be responsible for all fees charged.

Signature: ……. Date: ……..

AHC#: ……

In Case of Emergency Contact:

Name: ……

Home#: …… Bus#: ……

Physician's Name: ……

Phone#: ……..

Financial

Person Responsible for Account: ……

Name: ……

Home#: …… Bus#: ……..

Do you have dental insurance? ……..

Company Name: ……

Policy Holder: ……..

Group#: ……

Div#: ……

Cert#: ……..

Does your spouse have dental insurance?

Company Name: ……

Policy Holder: ……..

Group#: ……

Div#: ……

Birth date: ……..

Dr. John Schmidt – Dental History Information

Patient Name: _____

Dental History: Comments / Explanations

1. Are you having any pain or discomfort at this time? Yes ☐ No ☐ _____
2. Have you ever had a bad experience in the dentistry office? Yes ☐ No ☐ _____
3. Do you think you have gum problems? Yes ☐ No ☐ _____
4. Do you notice popping, clicking or soreness of the jaws or just in front of the ears? Yes ☐ No ☐ _____
5. Do you brush daily? Yes ☐ No ☐ _____
6. Do you floss daily? Yes ☐ No ☐ _____
7. When was your last dental visit? _____
   What was done? _____
   When were your last dental X-rays taken? _____
8. Have you ever had problems with dental freezing? (local anesthetic) Yes ☐ No ☐ _____
9. Have you ever had nitrous oxide (gas) or general anesthetic? Yes ☐ No ☐ _____
10. Describe in your own words your present dental problems(s): _____
    _____
    _____
    _____
    _____

Signature of Patient or Guardian: _____

Date: _____

Signature of Interviewer: _____

Medical History / Physical Evaluation Update:

Date: _____ Signature: _____ Changes: _____

Date: _____ Signature: _____ Changes: _____

Date: _____ Signature: _____ Changes: _____

Date: _____ Signature: _____ Changes: _____

Date: _____ Signature: _____ Changes: _____

Date: _____ Signature: _____ Changes: _____

Date: _____ Signature: _____ Changes: _____

Date: _____ Signature: _____ Changes: _____

Dr. John Schmidt – Personal Health Information

Patient Name: _____

Medical History:

Comments / Explanations

1. Have you been a patient in a hospital during the past 2 years? Yes ☐ No ☐ _____
2. Have you been under the care of a medical doctor during the last two years? Yes ☐ No ☐ _____
3. Have you taken any medicine or drugs during the past 2 years? Yes ☐ No ☐ _____
4. Are you allergic (i.e. itching, rash, swelling of hands, feet, eyes) or made sick by penicillin, aspiring, codeine or any drugs or medications? Yes ☐ No ☐ _____
5. Have you ever had any excessive bleeding requiring special treatment? Yes ☐ No ☐ _____
6. Check any of the following which you have had or have at present:

☐ Heart Failure	☐ Sinus Trouble	☐ Epilepsy or Seizures	_____
☐ Heart Disease or Attack	☐ Allergies or Hives	☐ Anemia	_____
☐ Angina Pectoris	☐ Diabetes	☐ Stroke	_____
☐ High Blood Pressure	☐ Thyroid Disease	☐ Kidney Trouble	_____
☐ Rheumatic Fever	☐ Chemotherapy (Cancer/Leukemia)	☐ Ulcers	_____
☐ Congenital Heart Lesions	☐ AIDS or HIV	☐ Arthritis	_____
☐ Scarlet Fever	☐ Hepatitis A (Infectious)	☐ Rheumatism	_____
☐ Artificial Heart Valve	☐ Hepatitis B (Serum)	☐ Cortisone Medicine	_____
☐ Heart Pacemaker	☐ Liver Disease	☐ Glaucoma	_____
☐ Heart Surgery	☐ Yellow Jaundice	☐ Pain in Jaw Joints	_____
☐ Artificial Joint	☐ Blood Transfusion	☐ Fainting or Dizzy Spells	_____
☐ Emphysema	☐ Drug Addiction	☐ Nervousness	_____
☐ Cough	☐ Hemophilia	☐ Psychiatric Treatment	_____
☐ Tuberculosis (TB)	☐ Venereal Disease (Syphilis/Gonorrhea)		_____
☐ Asthma	☐ Cold Sores	☐ Sickle Cell Trait/Disease	_____
☐ Hay Fever	☐ Genital Herpes	☐ Bruise Easily	_____

7. When you walk up stairs or take a walk, do you ever stop because of pain in your chest, shortness of breath, or because you are tired? Yes ☐ No ☐ _____
8. Do your ankles swell during the day? Yes ☐ No ☐ _____
9. Do you use more than two pillows to sleep? Yes ☐ No ☐ _____
10. Have you lost or gained more than 10 pounds in the past year? Yes ☐ No ☐ _____
11. Do you ever wake up from sleep short of breath? Yes ☐ No ☐ _____
12. Are you on a special diet? Yes ☐ No ☐ _____
13. Has your medical doctor ever said you have a cancer or tumor? Yes ☐ No ☐ _____
14. Do you have any disease, condition or problem not listed? Yes ☐ No ☐ _____
15. Women: Are you pregnant now? Yes ☐ No ☐
    Are you using birth control pills? Yes ☐ No ☐ _____
16. Please list your childhood diseases: _____

    _____

    _____
17. Are you currently in good health? Yes ☐ No ☐ _____

John K. Schmidt Professional Corp.

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 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 number, work telephone number, 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 our dental practice.

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 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 and 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 us to obtaining the 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**