Patient Registration Form

Patient Name : test pname
Preferred Name : test
Address : Akshya Nagar 1st Block 1st Cross, Rammurthy nagar, Bangalore-560016
City : test Province : test Postal Code : 333334
Email: test@gmail.com
Home Phone: 3456786543 Office Phone: 324234234234 Cell Phone: 3456789023
Emergency Contact: 7789456258 : 3432423423
Family Dentist: testd Family Physician: te4tewt
Specialist Physician: 44534 Date of Birth: 2021-12-15
Primary Insurance Company: test Subscriber Name: test
Subscriber Date of Birth: 2021-12-22 Policy/Plan # : 44
Certificate/ID #: 44
Secondary Insurance Company:: 44 Subscriber Name: 44
Subscriber Date of Birth: 2021-12-01 Policy/Plan #: 33
Certificate/ID #: 33
AHC #: 44

MEDICAL QUESTIONNAIRE

Please answer 'yes' or 'no' to each question.
Do you have or have you had any of the following:

Cardiovascular		Hematologic / Endocrine / Oncologic / Immune	
High blood pressure	: Yes	Frequent hunger	: Yes
Heart disease from childhood	: No	Frequent thirst	: No
Heart murmur	: Yes	Diabetes	: Yes
Rheumatic fever	: No	If yes, type	: test type
Pacemaker	: Yes	Thyroid disease	: Yes
Vascular graft / stent	: No	Hemophilia	: No
Heart valve replacement	: Yes	Sickle cell disease	: Yes
Heart attack	: No	Bleeding tendency	: No
Heart surgery	: Yes	Anemia	: Yes
Congestive heart failure	: No	Cancer	: No
Angina / chest pain	: Yes	Radiation therapy	: Yes
Irregular heart beat	: No	Chemotherapy	: No
Stroke	: Yes	HIV / AIDS	: Yes
Increase cholesterol	: No	Organ transplant	: No
		Blood transfusion	: Yes

Musculo-skeletal / developmental

Chronic jaw/facial pain	: Yes	Multiple sclerosis	: Yes
Chronic headache pain	: Yes	Cerebral palsy	: No
Chronic neck pain	: Yes	Dementia / alzheimer's	: Yes
Popping or clicking in your jaw	: Yes	Fainting	: No
Joint replacement	: Yes	Visual impairment	: Yes
Osteoarthritis	: Yes	Glaucoma	: No
Spinal cord injury	: Yes	Hearing Impairment	: Yes
Seizures	: Yes		

Gastro-intestinal / Genito-urinary

Hepatitis (A, B, C or other)	: Yes
Kidney dialysis	: No
Ulcers	: Yes
STI	: No
Denied permission to give blood	: Yes

Psychological

Anxiety / nervousness	: Yes
Depression	: No
Mental health treatment	: Yes
Insomnia	: No

Respiratory

Asthma	: Yes
Chronic sinus problems	: No
Night sweats	: Yes
Emphysema	: No
Tuberculosis	: Yes

Social History

Use tobacco products	: Yes
If yes, type and frequency	: test
Drink alcohol	: Yes
Daily alcohol	: Yes
Daily alcohol amount?	: test
Recreational drug use	: Yes

Any medical conditions not mentioned? :
test
Hospitalizations / Surgeries? :
test

Medications

Please list any and all medications, including herbal medications and over the counter drugs:
Medication 1 :
test

Allergies

Please list any and all allergies:
test

Bisphosphonates

Do you or have you ever taken a bisphosphonates medications (e.g. Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa or Bonefos)? : No

What dosage do you take and how long have you been or are taking it? :

test

Patient Signature

Date :2021-12-22

Doctor Signature

Date: 2021-12-15

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 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 files
• To invoice patients for dental services, to process payments or to collect unpaid accounts
• To process insurance claims for our patients both electronically via CDAnet and manually when applicable
• To send reminders to patients concerning the need for further dental examination or treatment
• To send patients information 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 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 known 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 a second opinion.
• To other dentists and dental specialists if the patient, with their consent, has been referred to us by the other dentist or dental specialist for treatment.
• To other dentists or 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 of the patient, with their consent, has been referred to us by other healthcare professionals to 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 inspect our records and interview our staff as part of its regulatory activities in the public interest.
I authorize release to my dental benefits plan administrator and the Canadian Dental Association, information contained in claims submitted electronically, when applicable. I also authorize the communication of information related to the coverage of services described to Dr. Shackleton Prof. Corp.
I consent to the collection, use and disclosure of my personal information as set out above. This authorization shall continue in effect until the undersigned revokes the same.

Patient Signature

Date: 2021-12-22 Print Patient Name: test pname

Parent or guardian Signature