

Welcome

The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

Please complete forms and bring them with you to your first visit. If you are a current patient of Cooper Dental, please inform us of any updates to your medical history or personal information.

Legal Name: _____ I like to be called: _____
Home address: _____
City: _____ Province: _____ Postal Code / Zipcode: _____
Date of Birth: _____ Marital Status: _____
Home phone: _____ Work phone: _____ Cell / Pager number: _____
E-mail address: _____
When is the best time to call you: _____ And where? _____
Employer: _____ Occupation: _____
Primary Insurance Company name: _____ Group #: _____ ID #: _____
Secondary Insurance Company name: _____ Group #: _____ ID #: _____
For insurance purposes, name of spouse: _____ Date Of Birth: _____
Special Interests or hobbies: _____
Whom can we thank for referring you to our office?: _____
Have you visited our website? : _____ Suggestions: _____

In case of emergency, is there someone in Calgary we can call for you?:

Name: _____ Phone Number: _____
Relationship to you: _____
Name of Personal Physician: _____ Phone Number: _____
Last visit with physician: _____ Current Health: Excellent Good Fair Poor
Do you smoke or use chewing tobacco? Yes No If yes, how much per day?: _____
Are you currently taking prescription medications, including herbal remedies? If yes, please list below:

For Women Only:

Are you pregnant? Yes No If yes, how many months? _____
Do you plan on becoming pregnant in the near future and when? _____
Have you had any serious medical problems within the past 5 years? Yes No If yes please explain:

DOWNTOWN PLUS 15

200 - 520 5 Avenue SW
Calgary, AB T2P 3R7

403.265.0367
DT@cooperdental.ca

COUGAR RIDGE SW

677 Cougar Ridge Drive SW
Calgary, AB T3H 5J2

403.685.5510
SW@cooperdental.ca

Have you ever had, or been treated for any of the following diseases or medical problems? **Please circle.**

- | | |
|------------------------------------|------------------------------------|
| Y N Heart attack / Stroke | Y N Heart murmur / Rheumatic Fever |
| Y N Hepatitis / Jaundice | Y N High / Low Blood Pressure |
| Y N Epilepsy / Seizures / Fainting | Y N Abnormal bleeding |
| Y N Cancer / Chemotherapy | Y N Kidney problems |
| Y N Psychiatric problems | Y N Diabetes |
| Y N Tuberculosis | Y N Drug / Alcohol abuse |
| Y N AIDS / HIV | Y N Anemia |
| Y N Depression | Y N Motor Vehicle Accident |

Have you ever been treated for any other illness not listed above? Yes No If yes, please explain:

Do you need to be pre-medicated before dental treatment? Yes No Don't know

Are you allergic to any of the following? Y N Metals Y N Penicillin Y N Aspirin

(Please circle) Y N Erythromycin Y N Codeine

Y N Dental Freezing Y N Others Explain:

Plastic Surgery? ie. Botox, collagen, etc. _____

How would you rate your anxiety level? (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Why have you come to the dentist today? _____

Many patients consult us for a second opinion. Have you seen another dentist for your dental needs?

If yes, please explain: _____

How would you describe the condition of your teeth and gums? Good Fair Poor

Are you currently in pain or discomfort with your teeth or gums? Yes No If yes, please explain:

The date of your last dental visit: _____ Previous dentist's name: _____

If you could wave a magic wand, and change anything about the appearance of your smile, what would you like to do? _____

If you could easily whiten your teeth, would you be interested? Yes No

How often do you brush your teeth? _____ Floss your teeth? _____

Do your gums bleed when you brush? Yes No Floss? Yes No

Have you ever experienced pain in your jaw joint? Yes No

Do you grind your teeth? Yes No

Have you ever been treated for TMJ (jaw joint) symptoms? Yes No If yes, please explain:

I understand that the information is correct to the best of my knowledge. I understand that the doctor only sees one patient at a time to maintain the highest quality of patient care. For this reason, I will provide 48 business hours notice if I must reschedule or I agree to pay \$150 fee. I agree to pay for all services rendered by this dental centre. I also give permission for the doctor to use my photos taken to be used for lecturing or educational purposes with my identity removed.

Date _____ Signature _____

DOWNTOWN PLUS 15

200 - 520 5 Avenue SW
Calgary, AB T2P 3R7

403.265.0367
DT@cooperdental.ca

COUGAR RIDGE SW

677 Cougar Ridge Drive SW
Calgary, AB T3H 5J2

403.685.5510
SW@cooperdental.ca

DENTAL OFFICE PRIVACY POLICY

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, home telephone numbers, 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 informational 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 patient's 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 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 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 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 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.

DOWNTOWN PLUS 15

200 - 520 5 Avenue SW
Calgary, AB T2P 3R7

403.265.0367
DT@cooperdental.ca

COUGAR RIDGE SW

677 Cougar Ridge Drive SW
Calgary, AB T3H 5J2

403.685.5510
SW@cooperdental.ca

PRIVACY CONSENT

Your privacy is important to us. As part of our commitment to providing you with the highest quality of service, we dedicate ourselves to maintaining the security, confidentiality and privacy of your personal information.

Please read our Privacy Policy as it explains how we will use, collect, disclose and protect your personal information.

Some of the uses and disclosures are a necessary part of our relationship with you. We want to ensure we have your consent to collect, use and disclose your personal information for the purpose discussed in our Privacy Policy, so we ask that you sign the consent form below.

From time to time you will be asked to update your information. All reasonable efforts are taken during our communications with you and emails are accessed through a secured browser on our end. However, emails are inherently insecure and you accept the risks of this type of communication.

I consent to Cooper Dental to obtaining, using and disclosing my personal information for the purpose described in the Privacy Policy.

PRINT NAME

SIGNATURE

DATE

WHERE APPLICABLE:

I certify that I am the legal guardian, trustee, agent or attorney for _____
and as such, have the authority to consent to the collection, use
and disclosure of the Patient's personal information as set out in
the Privacy Policy.

PATIENT'S NAME

GUARDIAN'S SIGNATURE

DOWNTOWN PLUS 15

200 - 520 5 Avenue SW
Calgary, AB T2P 3R7

403.265.0367
DT@cooperdental.ca

COUGAR RIDGE SW

677 Cougar Ridge Drive SW
Calgary, AB T3H 5J2

403.685.5510
SW@cooperdental.ca