Oasis Wellness Centre
201 13613 163 Street NW
Edmonton, AB
T5V 0B5

Oasis ORTHODONTICS

P: 780-457-5566
F: 780-456-7047
www.oasisorthodontics.ca

Patient Information

To become better acquainted and to be able to offer you the best possible care, we ask that you complete this

Date_________________________ Patient's Age____________

Patient's Name____ Birthday_____/______/________ ☐ Male ☐Female

Last First MI M D Y

Address____City____________________________Prov_______PC________________

Home Phone___________________________________ Cell Phone___________________________Work Phone_________________________________

Email____ Employer (Optional)____

Dentist's Name_________________________________ Family members seen by us____

Whom may we thank for referring you? ☐ Dentist ☐ Friend ☐ Family Member ☐ Oasis Staff ☐ Sign/Billboard ☐ Website

☐ Advertisement ____ ☐ Other ______________________________________

Parent Information (please complete if patient is under the age of 18)

Patient lives with: ☐ Mother ☐ Father ☐ Both Parents ☐ Other (please specify)____

Person responsible for account____Relation__________________________

Address____City__________________________Prov______PC_____________

(if different from the patient)

Home Phone_______________________________Work Phone______________________________Cell Phone_______________________________

Email____

Mother's Information

☐ Stepmother ☐ Guardian

Name____

Address____

(if different from patient)

Home Phone____

Work Phone____

Cell Phone____

Email____

Father's Information

☐ Stepfather ☐ Guardian

Name____

Address____

(if different from patient)

Home Phone____

Work Phone____

Cell Phone____

Email____

Insurance Information

Our office charges the patient/parent/guardian directly for all professional services rendered. We will complete the necessary forms so that you can receive the reimbursement to which you are entitled under your policy.

Do you have orthodontic coverage? ☐ Yes ☐ No ☐ Unsure

Primary

Insurance company name____________________________________

Group #______________________ID#____________________________

Subscriber's name____

Subscriber's birthday_________/__________/__________________

M D Y

Secondary

Insurance company name___________________________________

Group #____________________ID#___________________________

Subscriber's name____

Subscriber's birthday_________/___________/________________

M D Y

Do you receive funding through: ☐ Indian Affairs ☐ Social Assistance ☐ A.I.S.H. ☐ Ward of Government ☐ Cleft Palate Clinic

Continued on other side……..

Dental History

Reason for orthodontic consultation (chief concern)____

Is the patient happy with his/her smile? ☐ Yes ☐ No If not, what would he/she change?____

Has the patient ever had or been evaluated for orthodontic treatment? ☐ Yes ☐ No

Does the patient want treatment? ☐ Yes ☐ No ☐ Unsure

Has the patient now or ever experienced problems with their jaw joints (TMJ)? ☐ Yes ☐ No

If yes, please specify____

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

If yes, please specify____

Has the patient had or presently have any of the following habits? ☐ Thumb/finger sucking ☐ Lip biting ☐ Snoring ☐ Grinding ☐ Clenching ☐ Chronic mouth breathing ☐ Speech problems ☐ Tongue thrusting ☐ Chewing/eating problems ☐ Sinus problems ☐ Nail biting

Does the patient see the dentist regularly? ☐ Yes ☐ No How often does the patient brush?______________________

How often does the patient floss?______________________

Medical History

Physician's Name_________________________ Physician's Phone #________________Alberta Healthcare #____________________

Patient' s current physical health is ☐ Good ☐ Fair Is the patient currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain____

Does the patient require antibiotics before dental treatment? ☐ Yes ☐ No If yes, please explain________________________________

Is the patient taking any prescription or over the counter drugs? ☐ Yes ☐ No List all______________________________________

Does the patient have any allergies? ☐ Yes ☐ No List all____

Does the patient use tobacco? (smoking or chewing) ☐ Yes ☐ No

For women: Is the patient pregnant? ☐ Yes ☐ No ☐ Unsure Has the patient started her menstrual cycle? ☐ Yes ☐ No

DOES THE PATIENT HAVE NOW, OR EVER HAD ANY OF THE FOLLOWING?

	Y	N
Anemia/Blood Transfusion/Hemophilia	☐	☐
AIDS/HIV	☐	☐
Alcohol/Drug Abuse	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Artificial joints/bones/valves	☐	☐
Asthma	☐	☐
Cancer/Chemotherapy/Radiation treatment	☐	☐
Colitis/Crohn's	☐	☐
Cystic Fibrosis	☐	☐
Congenital heart defect/Mitral valve		

	Y	N
Diabetes	☐	☐
Difficulty breathing	☐	☐
Emotional/Psychiatric problems	☐	☐
Emphysema	☐	☐
Epilepsy/Seizures/Fainting	☐	☐
Fetal alcohol syndrome	☐	☐
Frequent headaches	☐	☐
Glaucoma	☐	☐
Hay fever	☐	☐
Hepatitis	☐	☐
Herpes	☐	☐
Heart murmur	☐	☐
	☐	☐

	Y	N
High blood pressure	☐	☐
Hospitalized for any reason	☐	☐
Kidney problems	☐	☐
Liver Disease	☐	☐
Lupus	☐	☐
Rheumatic/Scarlet fever	☐	☐
Shingles	☐	☐
Sickle cell disease/traits	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Venereal Disease	☐	☐

If yes to any of the above, please explain____

Describe any other medical condition not listed____

Signature

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

Signature of Patient/Parent/Guardian____Date____________________

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient/parent named herein.

Initial:__________Date:____________________

Comments:____

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Orthodontic 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 numbers, and work telephone numbers. (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 their 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 orthodontic 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 in the following situations:
  - Where we are seeking a second opinion and the patient has consented to us obtaining a second opinion.
  - Where the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
  - 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 orthodontic 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.

PRINTED NAME of Patient______________________________ SIGNATURE of Parent______________________________

DATE___________________

General Photography Release/Waiver`

Please select **one** of the following

I hereby GIVE my written consent to Oasis Orthodontics, to use my/my child's name and all photographs, for promotional and/or educational purposes.

Name of Patient____

Date________________Signature of Patient/Guardian______________________________

OR

I hereby GIVE my written consent to Oasis Orthodontics, to use only photographs of my/my child's teeth, NOT my/my child's name or facial photographs, for promotional and/or promotional purposes.

Name of Patient____

Date________________Signature of Patient/Guardian______________________________

OR

I hereby DO NOT give written consent to Oasis Orthodontics, to use my/my child's photographs for any type of promotional and /or educational purposes.

Name of Patient____

Date________________Signature of Patient/Guardian______________________________

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs.

I hereby release Oasis Orthodontics, its employees and any third parties involved in the creation or publication of marketing materials, from any liability for any claims by me or any third party in connection with my participation.