Dr. Erin J. Shave Inc.

REGISTRATION FORM - (PLEASE PRINT AND COMPLETE FULLY)

PATIENT INFORMATION

Patient's last name:	First	Middle initial:	Preferred name:	❑ Mr. ❑ Mst ❑ Dr.	❑ Miss ❑ Ms. ❑ Mrs

Is this your legal name? ❑ Yes ❑ No	Personal Health Care # S.I.N. or DL #	Birth date: MM / DD / YR	Age:	Sex: ❑ M ❑ F ❑ U

Apt /Street address:	City & Province	Postal code:

Home #	Work #	Cell #	Email Address

Occupation:	Employer:

Referred to clinic by (please check one box): ❑ Family/friend ❑ Website ❑ Family Doctor ❑ Other : _____

Name of referral:

Other family members seen here:

INSURANCE INFORMATION

(Please show your insurance card to the receptionist.)

IN CASE OF EMERGENCY

Name of next of kin or friend:	Relationship to patient:	Home phone no.:	Work phone no.:

I certify that I have read and understand the above information to the best of my knowledge. The above questions, and the health questionnaire have been accurately answered. I understand that providing incorrect information cans be dangerous to my health. I authorize the dentist too release any information including the diagnosisand the records of any treatment or examination rendered to me/or my child during the period of such dental care to third party payors and/or Health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am financially responsible to my dentist for the entire treatment rendered on my behalf or my dependents.
Please note: A fee may be charged for any missed/rescheduled appointments without two (2) full business days notification.

_____ _____

Patient/Guardian signature *Date*

COMPLETE OTHER SIDE PLEASE

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HEALTH QUESTIONNAIRE

To help ensure your well being while receiving treatment in our office, please answer the following questions.All information will be considered confidential and for our records only. I certify the above information is correct to the best of knowledge.

Last name:_____**First name:**_____**Middle initial:**_____**DOB:**_____

1. **Have you been examined and /or treated by a physician within the last year? YES NO ~ if yes, When?** _____

Physician's Name:_____**Physician's Phone:**_____

2. **Have you ever been seriously ill or hospitalized? YES NO *If yes, When?** _____
3. **Do you require any antibiotic coverage before any dental treatment? YES NO**
4. **Are you on blood thinners? YES/NO, *if YES the medication you are taking*:** _____

Please check (√) if you have ever had any of the following: * **Reviewed by:** _____

⊡ Angina - Chest pain		**SENSITIVITIES/ALLERGIES:**
⊡ Arthritis	⊡ Inflammatory rheumatism	⊡ Aspirin
⊡ Artificial Joints (hip/knee)	⊡ Lung/breathing problems	⊡ Codeine
⊡ Asthma	⊡ Mitral Valve Prolapse	⊡ Penicillin (Antibiotics)
⊡ Blood pressure problems	⊡ Mental health diagnosis	⊡ Sulfa
(CIRCLE) TYPE: HIGH or LOW	⊡ Transplants i.e.: Hip/Knee	⊡ Tylenol
⊡ Bruise easily	⊡ Pacemaker/artificial valves	⊡ Sulphite
⊡ Cancer	⊡ Prolong bleeding after injury	⊡ Latex
⊡ Radiation/ chemo treatment	⊡ Persistent cough	
⊡ Cold sores	⊡ Painful swollen joints	Woman only:
⊡ Congenital heart condition	⊡ Rheumatic fever	Are you pregnant? Yes No
⊡ Cortisone/steroid therapy	⊡ Recent change in appetite	If so, how many_____months
⊡ Diabetes	⊡ Severe headaches	
(CIRCLE) TYPE: Type 1 or Type 2	⊡ Sinus trouble/ Sore throats	(CIRCLE) Do you smoke or vape?
⊡ Difficulty swallowing	⊡ Stomach/intestinal problems	(CIRCLE)Tobacco use:Marijuana/chewing
⊡ Earaches	⊡ Tendency to faint	*** **Are you taking any medications?**
⊡ Feel thirsty much of the time	⊡ Trouble hearing	If so please list:
⊡ Frequent indigestion/vomiting	⊡ Tumors or growths	⊡
⊡ Heart Attack or Stroke ~ When?	⊡ Vertigo	⊡
⊡ Heart murmur/ palpitations	Other not listed:	⊡
⊡ Liver disease/ Hepatitis Type:	⊡	⊡
⊡ AIDS or HIV	⊡	⊡

Is there anything else concerning your health not listed that you think the doctor should know about? YES NO

_____

1) When was your last dental visit? _____
2) Have you had regular dental exams in the past? If yes what was done: _____
3) Have you had x-ray taken with in the last year? _____
4) Are you having dental discomfort or dental pain? _____
5) Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma? YES NO
6) I brush_____times a day. I floss_____times a day.
7) Do your gums bleed when brush or floss? NEVER SOMETIMES OFTEN
8) Do you have any oral habits: clenching, grinding, nail biting, thumb sucking? YES NO
9) Have you ever had professional tooth brushing & flossing instructions? YES NO
10) Have you had and problems with or unpleasant reactions to dental treatment? YES NO
11) Are you happy with the appearance of your teeth? YES NO
12) My primary concern is: _____

Date:_____**Signature:**_____

⊡ Patient ⊡ Parent ⊡ Guardian

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WELCOME

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 contact information from our patients (names, addresses, phone numbers, Email address, employer's names and work phone numbers) for the following purposes:

- To open & update patient files.
- To process credit card payments and 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 office.

Contact information is disclosed to third party health benefit providers and insurance companies when the patient has submitted a claim for reimbursement, or payment (of all or part of) the cost of dental treatment, or the patient 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 medical information from our patients about their health history, their family health history, physical condition, and dental treatments. Patients' medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' medical information is sometimes disclosed to the following:

1. Third party health benefit providers and insurance companies when 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.
2. Other dentists and dental specialists when we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
3. Other dentists and specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
4. Other dentists and dental specialists when those dentists have asked us, with the consent of the patient, to provide second opinion
5. 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 were to sell 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 British Columbia Dental Association & College, who may inspect our records and interview our staff as part of its regulatory activities in the public interest.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You may refuse to sign this acknowledgement ****

I, (full name)_____, did receive a copy of this office's Notice of Privacy Practices on (today's date) _____.

BELOW LINE FOR OFFICE USE

We attempted to obtain written acknowledgement of receipt of our Noticeof Privacy Practices, but it could not be obtained because:

( ) Individual refused to sign

( ) Communications barriers prohibited obtaining the acknowledgment

( ) An emergency situation prevented us from obtaining

( ) Other (please specify)

_____

_____

_____

Patient Full Name:_____ Date: _____