Dr. Shawn Higashi
NORTHLAND ORAL & MAXILLOFACIAL SURGERY CENTRE

patient registration & medical history questionnaire

Northland Professional Centre
4600 Crowchild Trail NW #204, Calgary, AB T3A 2L6
p. 403.286.5000 • f. 403.286.3333
www.northlandoralsurgery.com

PATIENT: MR. / MISS / MRS. / MS. / DR. ❑ MALE ❑ FEMALE ❑ OTHER

NAME _____

DATE OF BIRTH (D/M/Y) _____ /_____ /_____ AGE _____

ADDRESS _____

CITY _____ POSTAL CODE _____

HOME PHONE _____

CELL PHONE _____

OCCUPATION _____

BUSINESS PHONE _____

EMAIL _____

HEALTH CARD NUMBER (AHC) _____

WHO REFERRED YOU? _____

FAMILY DENTIST + PH.# _____

ORTHODONTIST + PH.# _____

OTHER DENTAL SPECIALIST + PH.# _____

_____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT:

_____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

_____

DATE OF BIRTH (D/M/Y) _____ /_____ /_____

EMPLOYER _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME _____

RELATIONSHIP _____

DAYTIME PHONE _____

CELL PHONE _____

NAME ON AHC _____

FAMILY PHYSICIAN + PH.# _____

_____

MEDICAL SPECIALISTS, (IF ANY), NAME + PH.# _____

_____

_____

The following information is required to enable us to provide you with the highest standard of care. All information is kept confidential. The doctor will review the questions and explain any that you do not understand. Please complete the entire form. If you need assistance, please notify one of our front desk team members and help will be provided.

HEIGHT _____ ft _____ in WEIGHT _____ lbs.

Are you being treated for any medical condition at the present or have you been treated within the past year? ..... ❑ Yes ❑ No ❑ Not sure/Maybe

If yes, why and who treated you? _____

When was your last medical checkup? _____

Has there been any change in your general health In the past year? If yes, please explain ..... ❑ Yes ❑ No ❑ Not sure/Maybe

_____

Have you had any serious illnesses? If yes, please explain ..... ❑ Yes ❑ No ❑ Not sure/Maybe

_____

Have you ever been hospitalized for any illnesses or operations? If yes, please explain ..... ❑ Yes ❑ No ❑ Not sure/Maybe

_____

Have you been hospitalized within the last 2 years? ..... ❑ Yes ❑ No ❑ Not sure/Maybe

Have you been out of Canada within the last 2 years? ..... ❑ Yes ❑ No ❑ Not sure/Maybe

If yes, where? _____

What medications are you taking? Please list any medication, non-prescription drugs or herbal supplements of any kind. (with dosage and frequency):

_____

_____

Do you have any allergies to medications, latex/rubber products, eggs/food etc? ❑ Yes ❑ No ❑ Not sure/Maybe

If yes, please list _____

Have you ever had an unexpected or adverse reaction to any medications, anesthetics or injections? ❑ Yes ❑ No ❑ Not sure/Maybe

If yes, please explain. _____

Do you have or have you ever had asthma? ❑ Yes ❑ No ❑ Not sure/Maybe

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (e.g. infective endocarditis), or a heart condition from birth (e.g. congenital heart disease)? ❑ Yes ❑ No ❑ Not sure/Maybe

Do you have a prosthetic or artificial joint? If yes, what year and what joint? ❑ Yes ❑ No ❑ Not sure/Maybe

_____

Do you have any conditions or therapies that could affect your immune system, e.g. leukaemia, AIDS, Organ Transplant, HIV infection, radiation therapy, chemotherapy? ❑ Yes ❑ No ❑ Not sure/Maybe

Have you ever had hepatitis, jaundice or liver disease? ❑ Yes ❑ No ❑ Not sure/Maybe

Are you taking any anticoagulation, anti-platelet (blood thinner) medications? Recent INR? ❑ Yes ❑ No ❑ Not sure/Maybe

_____

Do you have a bleeding problem or bleeding disorder? ❑ Yes ❑ No ❑ Not sure/Maybe

Are you on bisphosphonates/osteoporosis medication? (e.g. Fosamax, Didrocal, Actonel) ❑ Yes ❑ No

Do you have or have you ever had any of the following? Please check which apply:

❑ Chest pain/angina	❑ Rheumatic fever	❑ Pacemaker	❑ Corticosteroid therapy	❑ Seizure Disorder (epilepsy)
❑ Heart attack	❑ Bone, muscle or joint disorders	❑ Lung disease	❑ Diabetes	❑ Kidney disease
❑ Stroke	❑ Tuberculosis	❑ Stomach ulcers	❑ Thyroid disease	❑ Anxiety/Depression
❑ Heart murmur	❑ Cancer	❑ Arthritis	❑ Drug/alcohol dependency	❑ Shortness of breath
❑ Diet pill therapy	❑ High blood pressure	❑ Fainting spells	❑ Sleep Apnea/CPAP machine	❑ Immuno Suppression

Can you easily walk up a flight of stairs? ❑ Yes ❑ No

Are there any conditions or diseases not listed above that you have or have had? If yes, please list. ❑ Yes ❑ No ❑ Not sure/Maybe

Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)? ❑ Yes ❑ No ❑ Not sure/Maybe

If so, what? _____

What is your average intake of alcoholic beverages per week? _____

Do you use Marijuana? ❑ Recreational ❑ Medical ❑ Yes ❑ No

Do you smoke or chew tobacco products? ❑ Yes ❑ No

If yes, how much? _____

Do you vape? ❑ Yes ❑ No

If yes, how much? _____

Do you use any street drugs? ❑ Yes ❑ No

Are you suffering from any psychological or mental disorders? ❑ Yes ❑ No

Are you overly nervous during dental treatment? ❑ Yes ❑ No ❑ Not sure/Maybe

For women only: Are you pregnant or breast feeding? If pregnant, what is the expected delivery date? _____

Consent for the following: I hereby give consent for an examination, any necessary X-rays and/or any other necessary diagnostic procedures. I have read and understand the above Information and have answered all questions to the best of my knowledge.

Signature _____ Date _____

Signature _____ Date _____

Dr. Shawn Higashi

NORTHLAND ORAL & MAXILLOFACIAL SURGERY CENTRE

CONSENT FOR RELEASE OF INFORMATION:

At **Northland Oral & Maxillofacial Surgery Centre**, we are committed to protecting the privacy of our patient's personal information by utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use, and dispose of. In addition to the circumstances described, we also collect, use and dispose of personal information when permitted or required by law.

We collect information from our patients such as names, home, work and email addresses, home, work and cellular telephone numbers, birthdates, Personal Health 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, and 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 contact patients concerning the need for further dental examination and treatment.
- To identify patients when lab tests and special x-rays are required.

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted 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 payment of dental services.

We collect information from our patients about their health history (referred to as medical information). Patient's medical information is collected and used for the purpose of diagnosing medical/dental conditions and providing treatment.

Patient's medical information is disclosed:

- To third-party health benefit providers and insurance companies where patient has submitted a claim for reimbursement payment of all or part of the cost of dental/medical treatment or has asked us to submit a claim on their behalf.
- To other dental and medical specialists, where we are seeking a second opinion and the patient has consented to us to obtain a second opinion.
- To other dental and medical specialists if the patient, with their consent, has been referred to us by them 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 healthcare professionals, such as physicians, if the patient, with their consent, has been referred to us, to the other healthcare professional for either a second opinion or treatment.

If we ever consider 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 and Oral Surgeons are regulated by the Alberta Dental Association & 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 as above.

DATE: _____

PATIENT NAME (print): _____

SIGNATURE OF PATIENT / PARENT OR GUARDIAN: _____