Energy Square Prosthodontics / Central Alberta Prosthodontics

Registered Specialists in Prosthodontics and Restorative Dentistry

New Patient Personal History

Name ______________________________ Birthdate ____________
Surname First Day/Month/Year

Address ____
Street City Province

Postal Code ____________ Phone (home) ____________ Phone (cell) ____________

Email ______________________ AHC # ______________________

Employer ____________ Occupation ____________ Phone (work) ____________ Ext # ______

Spouse ______________________________ Spouse's Birthdate ____________
Name Day/Month/Year

Emergency Contact ____________ Relationship ____________ Phone ____________

Dental Insurance ______________________ Group # ____________ ID # ____________
Policy Holder/Insurance Company

______________________ Group # ____________ ID # ____________
Policy Holder/Insurance Company

Referred By ______________________ Phone ____________

Chief Complaint

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This is my authorization for Dr.Kieth Manning's office to **request and obtain** any personal information or information about my health history or dental history (including x-rays, notes, images, audiovisual recordings, documents, drawings, photographs, letters and any other information that is written, photographed, recorded, digitized or stored in any manner). This is also my authorization for Dr. Kieth Manning's office **to transfer, communicate or disclose** orally or in writing or in any manner, such information to any dental insurance carrier, dental laboratories, financial institutions and to any referring, consulting or treating medical or dental practitioner.

Recognize that we are committed to protecting the privacy of our patient's personal information and information related to health history or dental history. We are also committed to collection and safeguarding the information and transferring, communicating or disclosing the above information in a responsible and professional manner.

Note that dentists are regulated by the Alberta Dental Association (ADA) and College (C). Representatives of the ADA & C may inspect our records and interview our staff as part of its regulatory activities in the public interest.

In the event that the Dr. Manning or his staff were accidentally exposed to any of your blood or bodily fluids while completing dental procedures on you (for example a needle puncture wound), you also agree to blood testing for **blood borne viruses**.

Date ____________ Patient or Guardian's Signature ______________________ Dentist's Signature ______________________