Please complete this information form so we can provide the best care possible for you.

Today's Date:	
PERSONAL INFORMATION	
Name: *First* *Last*	Marital Status:
I like to be called:	Date of Birth:
Home Address:	City:
Postal Code:	Home Telephone:
Daytime Telephone:	Employer:
Cell Telephone:	Email Address:
What telephone number is best to use for contacting you?	
Referred By:	Emergency Contact (name and telephone #):
I hereby assign my benefits payable from dental claims submitted electronically to **Colette M Boileau Professional Corporation** and authorize payment directly to the corporation. This authorization shall continue in effect until the undersigned revokes the same. **Signature:** **Date:**	
INSURANCE COVERAGE PRIMARY	
Subscriber Name and Date of Birth:	Alberta Health Care #:
Insurance Company:	Policy or Group #:
Division #:	Certification or ID#:
INSURANCE COVERAGE SECONDARY	
Subscriber Name and Date of Birth:	Subscriber Date of Birth:
Insurance Company:	Policy #:
Division #:	Certification #:
PATIENTS COVERED BY DENTAL INSURANCE With the implementation of the Privacy Protection Act, in most circumstances, we are unable to call your insurance company and inquire about your policy and coverage. We encourage you to know your insurance policy, especially covered benefits, frequency limits and annual maximums.	

MEDICAL HISTORY

Name of Personal Physician:	Telephone Number:
Date of Last Visit:	Do you smoke or chew tobacco? **Yes No**
WOMEN: Are you pregnant or think you may be pregnant**?** **Yes No**	Have you ever had, or been treated for any of the following: **Please underline the conditions that apply to you**:

Are you currently taking any Prescription Medication?
Yes No If yes, please list:

Medication Name	**Purpose**

Heart attack	Stroke
High blood pressure	Kidney problems
Hepatitis	Diabetes
Jaundice	Drug abuse
Epilepsy	Alcohol abuse
Seizures/fainting	Anemia
Cancer	Tuberculosis
Heart murmur	Sleep Apnea
Rheumatic fever	HIV
Joint replacement	Chemotherapy
Abnormal bleeding	

Have you had any serious medical problem(s) or been hospitalized in the last 3 years? **Yes No** If yes, please explain:	Have you been treated for any other illness not listed above? **Yes No** If yes, please explain:

Are you allergic to any of the following medications: **If yes, please circle.**

Penicillin Erythromycin Sulpha Drugs Codeine Ibuprofen Other
If you circled OTHER, please list:

Are you allergic to any of the following: **If yes, please circle.**

Latex Preservatives Environmental Allergens Animals Other
If you circled OTHER, please list:

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

I understand that the information I have provided is correct to the best of my knowledge. I understand my information will be held in strictest confidence and only be used to help in my treatment.

Signature: **Date:**