



Dr. Mark Bochinski  
DENTIST

10051 - 117 Street  
Edmonton, Alberta T5K 1W7  
T (780) 482-6551  
F (780) 488-7902

## Patient Acquaintance Form

Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_ Gender \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birthday (mm/dd/yyyy) \_\_\_\_\_ E-mail \_\_\_\_\_

AHC # \_\_\_\_\_ Family Physician \_\_\_\_\_

Name and Phone number of Emergency Contact \_\_\_\_\_

*Our office will bill your Dental Insurance Company/Companies directly for payment; however you are responsible to us for any fees not paid by your dental insurance.*

### Medical, Dental Questionnaire

1. Please List all Current Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Are you currently taking Aspirin daily? Yes No Uncertain

3. Do you have any allergies? Yes No Uncertain

If yes, please list: \_\_\_\_\_

4. Have you ever had an unusual reaction to local anesthetic? Yes No Uncertain

If yes, please explain: \_\_\_\_\_

5. Are you a Diabetic? Yes No Uncertain

If yes, what type and how often do you test? \_\_\_\_\_

What is your normal range? \_\_\_\_\_

6. Have you ever been administered neuromodulator (Botox)? Yes No Uncertain

If yes, when was the last time you received treatment? \_\_\_\_\_

What area was it administered? \_\_\_\_\_

7. Are you in good health? Yes No Uncertain

8. Has there been any changes to your Medical History within the last year? Yes No Uncertain

If yes, please explain: \_\_\_\_\_

9. Have you ever been hospitalized for a serious illness or disease? Yes No Uncertain

If yes, please explain: \_\_\_\_\_

10. Date of your last visit to your doctor and reason for visit: \_\_\_\_\_

\_\_\_\_\_

11. Are you currently receiving treatment or regular medical care? Yes No Uncertain

If yes, for what conditions? \_\_\_\_\_



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HAVE YOU EVER BEEN TREATED BY A DOCTOR FOR: (please circle and underline any condition(s) that apply)

**General Health**

- 12. Blood disorders such as anemia or hemophilia? ..... Yes No Uncertain
- 13. Cancer, x-ray treatments or chemotherapy ..... Yes No Uncertain
- 14. Tumors or Growths? ..... Yes No Uncertain
- 15. Psoriasis, Seborrhea, or other skin diseases? ..... Yes No Uncertain
- 16. Have you ever lost weight without dieting, or gained weight recently? ..... Yes No Uncertain
- 17. Do you now use or have you ever used recreational drugs? ..... Yes No Uncertain
- 18. How many packs of cigarettes do you smoke per day? ..... \_\_\_\_\_ packs/day
- 19. How many drinks of beer, wine or liquor do you drink per day? ..... \_\_\_\_\_ drinks/day
- 20. For women, are you pregnant or do you think you are pregnant? ..... Yes No Uncertain

**Cardiovascular Health**

- 22. Damaged Heart valves or artificial heart valves, including:  
heart murmur, rheumatic fever, rheumatic heart disease, pacemaker ..... Yes No Uncertain
- 23. Congenital Heart Problems ..... Yes No Uncertain
- 24. Heart trouble, heart attack, high blood pressure, stroke ..... Yes No Uncertain
  - Do you have pain in your chest upon exertion? ..... Yes No Uncertain
  - Are you ever short of breath? ..... Yes No Uncertain
  - Do your ankles swell? ..... Yes No Uncertain

**Respiratory System**

- 25. Breathing problems, emphysema, tuberculosis, or other lung issues? ..... Yes No Uncertain
- 26. Asthma, hay fever, hives? ..... Yes No Uncertain

**Gastrointestinal System**

- 27. Stomach or Intestinal disease? ..... Yes No Uncertain
- 28. Hepatitis, jaundice, or liver disease? ..... Yes No Uncertain

**Nervous System**

- 29. Stroke, seizures, fainting spells, numbness, or other neurological issues? ..... Yes No Uncertain
- 30. Phobias, severe anxieties, depression, psychoses, unusual fears,  
or other mental problems? ..... Yes No Uncertain

**Genitourinary System**

- 31. Kidney infections, frequent urination, or renal (kidney) dialysis? ..... Yes No Uncertain
- 32. Syphilis, gonorrhea or genital herpes? ..... Yes No Uncertain
- 33. AIDS, AIDS-related condition or HIV positive? ..... Yes No Uncertain

**Other Organs**

- 34. Severe or frequent headaches? ..... Yes No Uncertain
- 35. Do you ever have complaints regarding your eyes? ..... Yes No Uncertain
- 36. Do you wear contact lenses? ..... Yes No Uncertain
- 37. Any facial or body piercing? ..... Yes No Uncertain

If yes, please list: \_\_\_\_\_

Signature of Patient: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

Signature \_\_\_\_\_ Date \_\_\_\_\_

if other than patient indicate relationship \_\_\_\_\_



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## Dr. Mark Bochinski P.C. Corp 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 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 the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services, ie. Mastercard or Visa.

We collect information from our patients about their 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 dental 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, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.

To other dentists and dental specialists if the patient, with their consent, had been referred by us to the other dentist or dental specialist for treatment.

To other dentist and dental specialists if the patient where those dentists have asked us, with the consent of the patient, to provide a second opinion.

To other healthcare providers such as physicians if the patient, with their consent, has been referred by us to the other provider for either a second opinion or treatment.

If we are ever considering 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 then 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 or 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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature



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## Dr. Bochinski's Dental Office

Please accept the below conditions regarding our office cancellation policy

I understand that the time booked for my appointment is reserved for me. If i am unable to keep my appointment I will notify Dr. Bochinski's Dental Office at 780-482-6551 at least 24 hours in advance. If i fail to provide adequate notice I understand that they reserve the right to charge a \$150.00 fee.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Additional Medical Questions

Are you, or have you recently been experiencing any of the following...

- |    |   |     |    |
|----|---|-----|----|
| 1. | New cough or shortness of breath? .....                     | Yes | No |
| 2. | New fever or chills in the last 24 hours? .....             | Yes | No |
| 3. | New onset Diarrhea? .....                                   | Yes | No |
| 4. | New undiagnosed rash, lesion, or break in the skin?.....    | Yes | No |
| 5. | Recent exposure to Infectious disease? E.g.chicken pox..... | Yes | No |
| 6. | History of Prion Disease? .....                             | Yes | No |
| 7. | Recent travel (where to)? .....                             | Yes | No |