New Patient Information and Dental History Form

Patient Information

Preferred method of contact: ☐Text ☐Email ☐Phone
Patient Name: _____
DOB: _____ Gender: ____
Address: _____
Phone: _____ Referred by: _____
Email: _____
Family Doctor: _____ Phone Number _____
Emergency Contact: _____ Phone Number _____

Insurance Information (if no insurance, please leave blank)

Primary Dental Insurance Name of Insured: _____ DOB: _____
Insurance Company: _____
Group/Plan/Policy #: _____ Certificate/ID #:_____
Insured's Employer Name: _____

Secondary Dental Insurance Name of Insured: _____ DOB:_____ _____
Insurance Company: _____
Group/Plan/Policy #: _____ Certificate/ID #:_____
Insured's Employer Name: _____

Dental History

Do you need to take antibiotics prior to dental appointments? _____
If yes, please list_____
Have you ever had complications following dental treatment? _____
When was your last dental visit? _____
Do your gums bleed when you brush or floss? _____
Do your teeth experience sensitivity to cold or hot temperatures or sweets? _____
Are any of your teeth currently causing you pain? _____
Do you grind your teeth (either consciously or during sleep)? _____
Have you ever had an allergic reaction to local anesthetics? _____
Are any of your teeth loose or are you concerned about any teeth loosening? _____
Do you currently have dental implants, dentures, or partials? _____
Have you ever had any surgery in your mouth? _____
Do you use tobacco, any recreational drugs, alcohol, e-cigarettes, chewing tobacco?
_____
Do your jaws crack, pop, or grind when you open widely? _____

Unit 2, 420 Allan St
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Cancellation/Missed Appointment Policy

We understand that emergencies come up and appointments sometimes need to be cancelled or changed. As a courtesy to all of our patients and staff, we ask that you let us know at least 48 hours in advance if you need to cancel or change your appointment. Since we have reserved that specific appointment time just for you, we ask that you show us the same care and consideration by giving us at least 48 hours' notice. **If you have had 2 missed or cancelled appointments without giving 48 hours' notice, then you may be charged a cancellation/missed appointment fee as determined by the Alberta Dental Fee guide.**

Consent for Services

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist/dental practice to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and that I may be billed for this remaining balance.

I understand that any preauthorizations for treatment sent to my insurance carrier on my behalf are just estimates and do not guarantee the exact amount that may be billed and/or covered by my insurance plan.

I understand that any treatment plans given to me are considered an estimate and that cost for actual treatment provided may change as adaptations to treatment plans can and do occur frequently in the dental field.

I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). This consent shall be considered in effect until rescinded or revoked.

_____ _____

Patient Signature (Parent/Guardian Signature) Date

_____

Patient Name (Printed)

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Medical History Form

Patient Name: _____DOB: _____ Gender: ____

Are you currently taking any prescription or non-prescription medications? (If yes, please list) _____
Do you have any known drug allergies? (If yes, please list) _____
Do you have any other allergies? (If yes, please list) _____
Do you have sensitivity or allergy to latex? _____
Have you been hospitalized within the last 4 years due to a surgery or illness? _____
Are you currently under the care of a physician due to a specific condition? _____

Please indicate with a checkmark if you have had any of the following (circle the condition that applies):

Anemia ___
Rheumatic/Scarlet Fever ___
Hyper/hypothyroidism ___
Hives ___
Jaundice ___
STD/STI ___
Stroke ___
Stomach Problems ___
Celiac Disease ___
Substance Abuse ___
Hearing Impaired___
Circulation problems ___
Cold Sores (Herpes) ___
Other_____
Pacemaker ___
Pregnancy (currently) ___
Pre-Medication ___
Radiation/Chemotherapy ___
Respiratory Problems ___

Emphysema ___
Arthritis ___
Sickle Cell Anemia ___
Kidney Disease ___
Blood Disorder ___
Cancer ___
Excessive Bruising ___
Glaucoma ___
Head/neck Injury___
Bronchitis/COPD ___
Mitral Valve Prolapse ___
Heart Attack ___
Heart Disease ___
Contraceptive use ___
Cortisone/Steroid use ___
Diabetes type 1/2 ___
Dizziness/Fainting ___
Eating Disorder ___

Hyper/hypoglycemia ___
Epilepsy ___
Asthma ___
Sinus Problems ___
Excessive Bleeding __
Ulcers ___
Joint Replacement ___
Liver Disease ___
Mental Illness ___
Chron's/Colitis ___
Tuberculosis___
Multiple Sclerosis ___
Organ Transplant ___
Heart Murmur ___
Hepatitis A/B/C ___
High/Low BP ___
HIV+ ___
Hodgkins Disease ___

Patient Signature (Parent/Guardian Signature) _____

Date _____

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