Welcome!

Kindly complete the following Confidential Patient information.

Patient Legal Name: _____You Prefer to be called: _____

Date of Birth: D/_____ M/_____YR/ _____ Sex: M F OTHER Age: _____

Mailing Address: _____ City: _____Prov: _____ Postal: _____

Home Ph: _____ Cell Ph: _____Email:_____

***Emergency Contact Name:** _____ **Phone:** _____

****How did you hear about our office?** Their Name? _____

Radio Ad Mountainview Albertan/Gazette Google Live in Area Facebook
Western Buy & Sell Other: _____

OFFICE POLICIES FOR TREATMENT

APPOINTMENT POLICY: Appointments are confirmed when booked. Courtesy reminders are given but are not an opportunity to cancel. As we schedule exclusively for each patient, we require a ***MINIMUN OF 2 BUSINESS DAYS (48 HOURS)*** advance notice to make any changes to OR cancel appointments. Advance notice allows us to schedule another patient who is waiting to see us.
A fee of $100 will be applied to your account if you fail to provide notice or do not show.
Thank you in advance for your consideration. _____ **Initial**

TREATMENT FEES: All patient portions are due at the time of visit. If your insurance company does not provide and electronic EOB the day of treatment, an estimated portion will be collected. The balance will be applied to your credit card on file (SEE BELOW) OR should you receive a statement for a balance, that portion is due within 7 days.
Overdue accounts will be subject to monthly interest fees. _____ **Initial**

DENTAL INSURANCE: *****Kindly provide your Insurance card to the front desk.****
Direct Billing to dental insurance is a courtesy we offer our patients, however your plan must be able to pay the dentist directly.
WE STRONGLY SUGGEST ALL PATIENTS BECOME FAMILIAR WITH YOUR PLAN MAXIMUMS, RESTRICTIONS AND LIMITATIONS. NOT ALL INSURANCE PLANS PROVIDE THIS INFO THE DENTAL OFFICE. _____ **Initial**

PLEASE COMPLETE BELOW IF YOU WISH US TO DIRECT BILL YOUR INSURANCE:

If you request direct billing to your dental plan, a valid credit card is required to be left on file. This card will also be charged for any unforeseen balance not collected at the time of visit and if not paid by your insurance plan.

Circle **VISA** **VISA DEBIT CARD** **Master Card** **MasterCard DEBIT** **Amex**

Card #: _____ Expiry Date: _____/_____ CVC: _____

Card Holder's Name: _____ Signature: _____

(This form will be shredded after entry into our secure data base)

MEDICAL HISTORY

Family Physician/Clinic Name: _____Most recent Exam: _____

Are you currently being treated for a medical condition or injury? Yes No

If yes, please explain: _____

Women ONLY: Are you pregnant? Yes No If yes, How many weeks? _____

***Do you require PREMEDICATION (antibiotics) prior to dental treatment? Yes No**

(ie: IF YOU HAVE HAD; heart surgery, heart murmur, hip or knee replacement, etc

PLEASE CHECK YES OR NO TO THE FOLLOWING MEDICAL CONDITIONS;

Yes	No		Yes	No	
		Anemia			HIV/AIDS/A.R.C.
		Arthritis			Blood Pressure Problems (High? or Low?)
		Artificial Joints			Kidney Disease
		Asthma			Liver Disease
		Blood Disease			Anxiety
		Diabetes			Mental Illness
		Dizziness			Pace Maker
		Epilepsy			Rheumatism
		Excessive Bleeding			Sinus Problems
		Fainting			Stomach Problems
		Glaucoma			Stroke
		Head Injury			Tuberculosis
		Heart Disease			Ulcers
		Heart Murmur			Venereal Disease
		Hepatitis *(Type: _____)			Do you smoke or chew tobacco?
		Cancer *(Type: _____)			

Other not listed? _____

ARE YOU ALLERGIC OR HAVE YOU EVER HAD A REACTION TO THE FOLLOWING?

Yes	No	
		Local Anesthetic (Freezing)
		Penicillin or other Antibiotics, **please list:**
		Codeine, Demerol or other narcotics, **please list**
		Metals, **please list**
		Latex

Please list any current medications, vitamins, herbs or supplements or other medical conditions not listed.
*(you can also inform us of your pharmacy and we will obtain a list)

DENTAL HISTORY

Are you currently experiencing any tooth pain or dental problems? Yes No

If Yes, please explain: _____

Please check off each question

Yes	No		Yes	No	
		Are you nervous or apprehensive about dental treatment? If yes, what is your biggest concern? _____			Does the saliva in your mouth seem too little?
					Does the saliva in your mouth seem to much?
		Are you interested in discussing sedation dentistry?			Do you gag easily?
		Have you had problems with previous dental treatment?			Have you ever noticed slow-healing sore in your mouth?
		Would you like to keep all your teeth for life?			Have you had previous orthodontic (braces) treatment? When? _____
		Are you satisfied with the appearance of your teeth?			**Would you like to have straighter teeth?**
		Does food catch between your teeth?			
		Do you have difficulty in chewing your food?			Do you experience pain when you chew?
		Do you avoid brushing any part of your mouth because of pain?			Do you have temporomandibular jaw disorder (TMD)?
		Are your teeth sensitive to cold?			**Do you clench or grind your teeth at day or night?**
		Are your teeth sensitive to heat?			Do you have sleep problems?
		Are your teeth sensitive to sweets?			**Would you like to have whiter teeth?**
		Are your teeth sensitive to sours?			Do you notice an unpleasant taste or odor in your mouth?
		Do your gums bleed when you brush or floss?			Do you wear dentures?
		Are you a habitual gum chewer?			Do you have any missing teeth?
		Have you ever had an injury to your face or jaw?			**Are you interested in replacing your missing teeth?**
		Are you a mouth breather?			Do you have any dental implants?

How often do you brush your teeth? _____ How often do you floss? _____

Do you have an electric toothbrush or manual toothbrush? _____

Do you use any other homecare oral health aids? _____

Who was your Previous Dentist? _____ Last visit Date?_____

What would you change about your smile if you could? _____

TREATMENT CONSENT/RELEASE AUTHORIZATION

I, the undersigned authorize Didsbury Dental Centre to perform any necessary dental services and oral surgery that I may need during my diagnosis and treatment with my informed consent. I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. I understand that all dental fees are my sole responsibility .

_____ _____ _____

Signature of Patient/Guardian Print Name Date