Welcome!

Kindly complete the following ***Confidential*** ***Registration form***

DIDSBURY DENTAL CENTRE

Patient Name: _____ **Prefer to be called**:_____
FIRST LAST

Date of Birth: *Day*_____*Month*_____*Year*_____ Sex: M ☐ F ☐ OTHER ☐ **Age**: _____

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

Home Ph: _____ Cell/Mobile Ph: _____ Email:_____

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

WHO REFERRED YOU TO US, OR HOW DID YOU HEAR ABOUT US?

☐ Albertan/Gazette Paper ☐ Google Search ☐ Live in Area ☐ Facebook ☐ Radio Ad/Colts Hockey
☐ Western Buy & Sell Ad ☐ Three Hills Capital Paper ☐ Friend/Family Name: _____

PLEASE READ & INITIAL OUR OFFICE POLICIES ~ Thank you!

OUR APPOINTMENT POLICY/CANCELLATION POLICY: Appointments are confirmed when booked. Courtesy reminders calls/texts/ emails are given but are not opportunites to cancel short notice. Each scheduled appointment is exclusively for you, therefore we REQUIRE a ***MINIMUN OF 2 BUSINESS DAYS (48 HOURS)*** advance notice to make any changes to OR to cancel any appointment. A **$100** fee will be applied to your account if you fail to provide sufficient notice or do not show to your reserved time. This Advance notice allows us to schedule another patient who has been waiting to see us. We sincerely thank you in advance for your cooperation and consideration. _____ Initial

**VERY IMPORTANT: Extensive Treatment such as dental implant surgery, Sedation treatment, IV Sedation Surgeries, ETC. require a deposit to reserve time and require minimum of 4 business days notice to change or cancel & are subject to loss of deposit. Additional details are discussed at scheduling such treatments.

TREATMENT FEES/DENTAL ACCOUNTS: All patient portions are due at the time of visit. If your insurance company does not provide confirmation of their exact payment at the time of visit, we will collect an estimated portion based on your coverage details. Once we receive insurance payment, we will then charge the unforeseen balance to your credit card on your account. (SEE BELOW) *Should a statement be received for a dental balance, please note that balance is due within 7 days. **Overdue accounts are subject to 5% interest charges until the balance is paid _____ Initial

DENTAL INSURANCE: ***Kindly provide your Insurance card & plan breakdown to the front desk.**

Direct Billing to dental insurance is a courtesy we offer our patients; however your plan must be set up to pay the dentist directly. (Referred to as Assignment") NOTE: 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 DENTAL 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.

Card type **VISA** _____ **VISA DEBIT CARD** _____ **Master Card** _____

Card Holder's Name: _____Card #: _____

Expiry Date: _____ CVC: _____ Signature: _____

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

CONFIDENTIAL MEDICAL HISTORY

Family Physician/Clinic Name: _____ Date of Most recent Visit: _____

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

If yes, please explain: _____

***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 MEDICAL CONDITION 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) _____

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

DENTAL HISTORY

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

If Yes, please explain: _____

Please answer 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? _____x's per day / week Do you Floss? Yes No How often ? _____

Do you use electric OR manual toothbrush? _____Do you use any other Oral Health Aids _____

Name of your Previous Dentist? _____ Last visit Date?_____

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

Are you interested in Orthodontic Treatment to straighten your teeth or repair any crowding? _____

Are you interested in hearing about any Cosmetic Dentistry? _____ (resin veneers, crowns, veneers, bonding, etc)

TREATMENT CONSENT & FEE CONSENT

I, the undersigned authorize the dentist & dental team of **Didsbury Dental Centre** to perform any necessary dental services and radiographs that I may need during my diagnosis and treatment with my informed consent. I certify that the medical information provided is accurate and complete to the best of my knowledge. I understand that all fees associated with my treatment, whether I have dental insurance or not, is my full responsibility and I agree to pay for my dental services.

_____ _____ _____

Signature of Patient/Guardian **PRINT NAME** **Date**