

NEW PATIENT INFORMATION

First Name	Last Name	Date of Birth	Preferred Pronoun	
Address	City	Province	Postal Code	
	Email			
EMERGENCY CONTACT				
Name	Phone	Relationship		
How did you hear about our office?		_ What are your primary dental cor	ncerns?	
When and where was your last dental visit?				
PATIENT DENTAL HISTO	RY			
Do your gums bleed while brushing or flossing?		Yes No		
Are your teeth sensitive to hot, cold or sweets?		Yes No		
Do you feel pain to any of your teeth?		Yes No		
Have you noticed any loose teeth?		Yes No		
Do you have any missing teeth?		Yes No		
Have you had any head, neck or jaw injuries?		Yes No		
Do you notice any wear on your teeth?		Yes No		
Have you experienced any pain in jaw or near your ears?		Yes No		
Do you wear any sort of nighttime appliance?		Yes No		
Have you ever had orthodont	tic treatment?	Yes No		
Are you interested in straight	ening your teeth?	Yes No		
Are you interested in whitening	ng?	Yes No		
Have you ever had any comp	plications with previous dental treatments?	Yes No		
Have you had an unpleasant dental experience?		Yes No		
Are you nervous during dental treatment?		Yes No		
Are you interested in sedation dentistry?		Yes No		





MEDICAL HISTORY

At our practice, we take a whole-body approach to dental care. Your mouth is an important part of your overall health, and many medical conditions, medications, and lifestyle factors can impact your oral health — just as oral health can affect the rest of your body. By understanding your full medical history, we can provide care that supports not just your teeth and gums, but your total well-being

Your information is always kept strictly confidential and used only to provide you with the safest, most effective care possible.

FAMILY PHYSICAN INFORMATION				
Name	Phone			
Are you currently being treated for any medical co	ondition? Yes No			
If yes, please describe				
Are you taking any medications, non-prescription drugs or herbal supplements?				
if yes please list them including dosage and w	hat they are prescribed for			
Do you have any allergies? Yes No				
If yes, what are they?				
MEDICAL QUESTIONNAIRE				
Have you been recommended to take antibiotics	before dental treatment? Yes No			
Do you have a prosthetic or artificial joint?				
Do you have or have you ever had an artificial valve?				
Do you have or had any heart or blood pressure problems?				
Do you have or had congenital heart disease?	Yes No			
Have you ever had bacterial endocarditis?				
Do you have or had asthma?				
Do you have a bleeding problem or disorder?	」Yes □ No			
Do you have any condition that could affect your in	mmune system?			
Do you have or have you ever had any of the follow	owing? (check all that apply)			
Anemia	Heart attack	Rheumatic fever		
Anxiety	Hepatitis A	Sinus Trouble		
Cancer	Hepatitis B or C	Stroke		
Chest pain	HIV Positive	Stomach ulcers		
Cold sores	Kidney problems	☐ Thyroid disease		
Depression	Liver disease	Tuberculosis		
Diabetes	Lung disease	Tumors		
Epilepsy or Seizures	Osteoporosis			
Do you have any condition that is not listed? Yes No If yes, please describe				



Calgary, AB, T2L 1V9
Phone (403) 282-7933
Fax (403) 284-9675

3604 52 Ave NW, #206

FOR WOMEN ONLY	
Pregnant? Yes No Nursing?	Yes No
COMPREHENSIVE QUESTIONAIRE	
health is closely linked to many systemic conditions, including	ionnaire is designed to give us a deeper understanding of your overall health. Ora g airway and breathing disorders (such as sleep apnea), temporomandibular joint e. In addition to your medical and dental history, we include questions related to tyle habits.
By evaluating the connection between the mouth and the res	t of the body, we can deliver more precise, preventive, and personalized care.
Do you experience any of the following:	
Daytime fatigue Yes No	Difficulty falling/staying asleep Yes No
Dry mouth or lips Yes No	Snoring Yes No
Feeling unrefreshed upon waking Yes No	Frequent waking throughout sleep Yes No
Gagging easily Yes No	CPAP intolerance Yes No
Ear congestion or trouble hearing Yes No	Headaches Yes No
Jaw clicking/popping Yes No	Jaw locking Yes No
Limited mouth opening Yes No	Pain when chewing Yes No
DENTAL INSURANCE AND PAYMENT	
Do you have insurance?	Do you have secondary insurance? Yes No
Policy holder's name	Policy holder's name
Policy holder's DOB	Policy holder's DOB
Name of Ins. Co	Name of Ins. Co
Group/Policy #	Group/Policy #
Member ID	Member ID

Employer______ Employer_____

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Fax



PAYMENT OF	PTIONS (Please select one)		
Option 1 -	1 - Pay in Full at Time of Service You agree to pay the full cost of treatment on the day of service. We are happy to assist you in submitting your claim to your insurance provider for reimbursement.		
Option 2 -	2 - Direct Insurance Billing We will bill your insurance directly. Any amounts not covered by your insurance are your responsibility and must be paid on the day of service.		
Credit Card I	nformation		
(Optional – if you	would like us to handle your balance for you)		
First NameLast Name			
Card Type U	/isa Amex Mastercard		
Credit Card Numb	berSecurity Code (CVV)		
Expiration Date (r	mm/yyyy)		
	, I consent to the financial responsibility for any amounts not covered by my dental insurance for the dental		
treatments provid	led, and consent us to charge your credit card on file.		
Signature	Date		

PATIENT PRIVACY CONSENT

Consent For Release Of Patient Information

We are committed to protecting the privacy of our patients' personal information and to utilizing personal information in a professional and responsible manner. This document summarizes some of the personal information that we collect, use, and disclose. In addition to the circumstances in this form, we also collect, use, and disclose personal information when permitted or required by the law. We collect information from our patients such as names, home address, work address, home/cellular telephone numbers, work telephone numbers, and email addresses. (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 collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health parties or insurance companies.
- To send reminders to patients concerning the need for further examination or treatment.
- To send patients informational material about our office, dental materials, or services offered.
- To follow up with treatment and/or customer service.

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How We Collect And Disclose Your Patient Information

Contact information is disclosed to insurance companies, third-party health benefit providers where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment and has authorized us to submit a claim on their behalf. Financial information may be collected to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family 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 for the following purposes:

- 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 the patient has asked us to submit a claim on their behalf.
- To other dentists and dental specialists, where seeking a second opinion and the patient has consented to seek a second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- To the other health care professionals such as physicians if the patient, with their consent, has been referred to us by the other health care professional for either a second opinion or treatment

Note: Dentists are regulated by the local Dental Association and College, which may inspect our records and interview our staff as part of regulatory activities in the public interest.

Cancellations & Missed Appointments

We try very hard to accommodate your schedules when booking appointments. This time is reserved just for you and has been scheduled by you. In order to give you the best care possible and to be fair to all our patients and to our team, we ask that you make every effort to keep these appointments.

If you are unable to keep your appointment, we ask that you give us at least two business days' notice. Otherwise, a fee of \$75.00 will apply.

General Release

I, the undersigned, certify that I have provided an accurate and complete personal, medical, and dental history, and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform all diagnostic procedures, including and not limited to x-rays and photographs, that may be required to determine necessary treatment, and to perform necessary or advisable treatment.

I understand that information provided from or to my medical doctor or another healthcare provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used, and disclosed within the guidelines of the policy. I understand that my dental insurance may not cover entirely the total fee of services provided. I understand that I am responsible for payment of the dental services for myself and my dependents, and I assume responsibility for fees associated with these services.

Print Name of Signing Person	_Email of Signing Person	
Signature	_Date	
This form was signed by Patient Parent Spouse Guardian	Other	
If other please explain		