NORTHWEST DENTAL

3604 52 Ave NW, #206
Calgary, AB, T2L 1V9

Phone (403) 282-7933
Fax (403) 284-9675

# NEW PATIENT INFORMATION

First Name_____Last Name_____Date of Birth_____Preferred Pronoun_____

Address_____City_____Province_____Postal Code_____

Phone Number_____Email_____

## EMERGENCY CONTACT

Name_____Phone_____Relationship_____

How did you hear about our office?_____ What are your primary dental concerns?_____

When and where was your last dental visit?_____

## PATIENT DENTAL HISTORY

| | | |
|---|---|---|
| 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 orthodontic treatment? | ☐ Yes | ☐ No |
| Are you interested in straightening your teeth? | ☐ Yes | ☐ No |
| Are you interested in whitening? | ☐ Yes | ☐ No |
| Have you ever had any complications 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 |

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# 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 condition? ☐ Yes ☐ No

If yes, please describe_____

Are you taking any medications, non-prescription drugs or herbal supplements? ☐ Yes ☐ No

if yes please list them including dosage and what 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? ☐ Yes ☐ No

Do you have or have you ever had an artificial valve? ☐ Yes ☐ No

Do you have or had any heart or blood pressure problems? ☐ Yes ☐ No

Do you have or had congenital heart disease? ☐ Yes ☐ No

Have you ever had bacterial endocarditis? ☐ Yes ☐ No

Do you have or had asthma? ☐ Yes ☐ No

Do you have a bleeding problem or disorder? ☐ Yes ☐ No

Do you have any condition that could affect your immune system? ☐ Yes ☐ No

Do you have or have you ever had any of the following? (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_____

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## FOR WOMEN ONLY

Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

## COMPREHENSIVE QUESTIONAIRE

*As part of our whole-body approach to dental care, this questionnaire is designed to give us a deeper understanding of your overall health. Oral health is closely linked to many systemic conditions, including airway and breathing disorders (such as sleep apnea), temporomandibular joint (TMJ) dysfunction, cardiovascular health, diabetes, and more. In addition to your medical and dental history, we include questions related to sleep quality, jaw function, posture, nutrition, stress, and lifestyle habits.*

*By evaluating the connection between the mouth and the rest of the body, we can deliver more precise, preventive, and personalized care.*

Do you experience any of the following:

Daytime fatigue ☐ Yes ☐ No

Dry mouth or lips ☐ Yes ☐ No

Feeling unrefreshed upon waking ☐ Yes ☐ No

Gagging easily ☐ Yes ☐ No

Ear congestion or trouble hearing ☐ Yes ☐ No

Jaw clicking/popping ☐ Yes ☐ No

Limited mouth opening ☐ Yes ☐ No

Difficulty falling/staying asleep ☐ Yes ☐ No

Snoring ☐ Yes ☐ No

Frequent waking throughout sleep ☐ Yes ☐ No

CPAP intolerance ☐ Yes ☐ No

Headaches ☐ Yes ☐ No

Jaw locking ☐ Yes ☐ No

Pain when chewing ☐ Yes ☐ No

## DENTAL INSURANCE AND PAYMENT

Do you have insurance? ☐ Yes ☐ No

Policy holder's name _____

Policy holder's DOB _____

Name of Ins. Co. _____

Group/Policy # _____

Member ID _____

Employer _____

Do you have secondary insurance? ☐ Yes ☐ No

Policy holder's name _____

Policy holder's DOB _____

Name of Ins. Co. _____

Group/Policy # _____

Member ID _____

Employer _____

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## PAYMENT OPTIONS (Please select one)

☐ **Option 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 - 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 Information

*(Optional – if you would like us to handle your balance for you)*

First Name_____Last Name_____

Card Type ☐ Visa ☐ Amex ☐ Mastercard

Credit Card Number_____Security Code (CVV)_____

Expiration Date (mm/yyyy)_____

_____, I consent to the financial responsibility for any amounts not covered by my dental insurance for the dental treatments provided, 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_____