



# Alpha Dental Care

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## PATIENT INFORMATION

**Name:** \_\_\_\_\_ **Phone (Home):** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **(Work):** \_\_\_\_\_  
**(City/Prov)** \_\_\_\_\_ **( Cell )::** \_\_\_\_\_  
**(Postal Code)** \_\_\_\_\_ **E-mail:** \_\_\_\_\_  
**Date of Birth:** (Day/Month/Year) \_\_\_\_\_  
**How did you find our office?** \_\_\_\_\_

## OFFICE POLICY

Please help us maintain the timely operation of our office so that we may assure you and other patients of prompt and uninterrupted treatment. Once you have made an appointment this time is reserved for you, therefore at least **48 HOURS NOTICE** must be given if cancellation is absolutely necessary, otherwise a serious delay in treatment may develop and a cancellation fee charged.

Treatment is to be paid for in full at the end of each appointment.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_



Alpha Dental Care



**DENTAL OFFICE PERSONAL INFORMATION CONSENT FORM**

We are committed to protecting the privacy of our patients’ personal information in a responsible and professional manner. This document summarizes some person information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, home telephone numbers, work phone numbers, and email addresses. ( collectively referred to as “ Contact Information”)

Contact information is collected and used for the following and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third party health benefit providers and insurance companies.
- To send reminders to patients concerning the needs for further dental examination or treatment.
- To send patients informational materials about our dental practice.

Contact information is disclosed to the 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 has asked us to submit a claim on the patient’s behalf.

Financial information may be collected in order 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”) Patient’s medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients’ Medical information is disclosed:

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

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as appropriate to any investigations.

I consent to the collection, use and disclosure of my personal information as set out above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature



Alpha Dental Care



## SNORING & SLEEP APNEA SCREENING FORM

Patient Name (PRINT) \_\_\_\_\_

Date \_\_\_\_\_

### Epworth Sleepiness Scale

Please indicate how likely you are to doze off or fall asleep in the following situations:  
(0=never, 1=slight, 2=moderate, 3=high chance of dozing)

CIRCLE ONE RESPONSE FOR EACH QUESTION

Sitting and reading.....	0	1	2	3
Watching television.....	0	1	2	3
Sitting in a public place.....	0	1	2	3
As a passenger in a car for one hour.....	0	1	2	3
Driving a car stopped for a few minutes in traffic.....	0	1	2	3
Sitting & talking to someone.....	0	1	2	3
Sitting down quietly after lunch .....	0	1	2	3
Lying down to rest in the afternoon.....	0	1	2	3

**Total Score:** \_\_\_\_\_

### Subjective Sleep Evaluation

Please circle one yes or no response for each question

	No(0)	Yes(1)
Has anyone ever told you that you snore?.....	0	1
Do you wake up at night or in the mornings with headaches?.....	0	1
Do you experience fatigue during the day?.....	0	1
Do you have high blood pressure?.....	0	1

**Total Score:** \_\_\_\_\_



**DENTAL HISTORY QUESTIONNAIRE**

**PREVIOUS DENTAL HISTORY**

1. When was your last dental visit?(approximately) \_\_\_\_\_  
 What was done: exam, cleaning, fillings, extractions, other? \_\_\_\_\_  
 Dentist's name and city? \_\_\_\_\_
2. Have you ever had complications associated with previous dental treatment? \_\_\_\_\_
3. Why did you leave your last dentist? \_\_\_\_\_
4. What did you like **most** about your last dentist? \_\_\_\_\_
5. What did you like **least** about your last dentist? \_\_\_\_\_
6. Have you ever had injury to your face, jaw, or teeth? \_\_\_\_\_
7. Have you ever had a bad reaction to dental freezing? \_\_\_\_\_ OR are you difficult to freeze? \_\_\_\_\_
8. How often do you brush? \_\_\_\_\_ floss? \_\_\_\_\_ use other aids? \_\_\_\_\_
9. Have you ever been treated for any of the following? \_\_\_\_\_

*Orthodontics*  
*Periodontics*  
*Jaw surgery*

*Root canal therapy*  
*Wisdom teeth extracted*  
*Crowns and bridges*

*Bite adjusting appliance*  
*Partial or full dentures*

**PRESENT DENTAL CONCERNS**

1. What dental problems concern you at present? (if any) \_\_\_\_\_
2. Do you have any of the following dental problems:  
 \_\_\_ teeth sensitive to heat, cold, pressure, sweets      \_\_\_ swollen or tender gums  
 \_\_\_ bad breath or bad taste in mouth                      \_\_\_ loose teeth  
 \_\_\_ gums that bleed when brushing or flossing            \_\_\_ improper fitting dentures
3. Are you dissatisfied with the appearance of your teeth? \_\_\_\_\_ If so, why? \_\_\_\_\_
4. Are you nervous about dental treatment? \_\_\_\_\_ If so, why? \_\_\_\_\_

**TMJ (JAW RELATED CONCERNS)**

1. Does your jaw click, pop, grate, lock, or cause you pain? \_\_\_\_\_  
 How often? \_\_\_\_\_
2. Do you have difficulty in opening your mouth? \_\_\_\_\_
3. Do you have frequent headaches, dizziness, neck stiffness or ear problems? \_\_\_\_\_  
 How often? \_\_\_\_\_
4. Are you aware of clenching or grinding your teeth? \_\_\_\_\_ For how long? \_\_\_\_\_

**PATIENT/PARENT CONSENT:** This is to certify that I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic or other drugs as indicated and will assume responsibility for fees associated with those procedures.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_



*Alpha Dental Care*



## **SYMPTOMS**

**If you experience any of the following symptoms,  
please check below:**

1.  Headaches
2.  TMJ pain
3.  TMJ noise
4.  Snoring
5.  Trouble falling asleep or remaining asleep
6.  Limited opening
7.  Ear congestion
8.  Vertigo (dizziness)
9.  Tinnitus (ringing in the ears)
10.  Dysphagia (difficulty swallowing)
11.  Loose teeth
12.  Clenching/Bruxing
13.  Facial pain (non-specific)
14.  Sensitive teeth
15.  Difficulty chewing
16.  Postural problems
17.  Parasthesia of fingertips (tingling)
18.  Thermal sensitivity (hot and cold)
19.  Trigeminal Neuralgia (facial nerve pain)
20.  Bell's Palsy
21.  Anxiety



**MEDICAL HISTORY QUESTIONNAIRE**

**MEDICAL ALERT:**

**In case of Emergency, we should notify:**

**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Daytime phone:** \_\_\_\_\_

**Name of Family Doctor:** \_\_\_\_\_

**Phone or Address:** \_\_\_\_\_

\_\_\_\_\_

**(1) Name of Medical Specialist:**

\_\_\_\_\_

**Specialty:** \_\_\_\_\_

**Phone or Address:** \_\_\_\_\_

**(2) Name of Medical Specialist:**

\_\_\_\_\_

**Specialty:** \_\_\_\_\_

**Phone or Address:** \_\_\_\_\_

**The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.**

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?  Yes  No

2. When was your last medical check-up?

3. Has there been any change in your general health in the past year? If yes, please explain.  Yes  No  Not sure/Maybe

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.  Yes  No

5. Do you experience difficulty sleeping?  Yes  No

6. Do you wake during the night?  Yes  No  Not Sure/Maybe

7. On average, how many hours do you sleep per night?

8. Do you have any allergies? If yes, please list using the categories below:  
a) Medications  Yes  No  Not sure/Maybe  
b) Latex/rubber products  
c) Other e.g. hay fever, foods

9. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.  Yes  No  Not sure/Maybe

10. Do you have or have you ever had asthma?  Yes  No  Not sure/Maybe

11. Do you have or have you ever had any heart or blood pressure problems?  Yes  No  Not sure/Maybe



12. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?  Yes  No  Not sure/Maybe

13. Do you have a prosthetic or artificial joint?  Yes  No

14. Have you ever been advised by your doctor to take antibiotics before dental treatment?  Yes  No  Not sure/Maybe

15. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?  Yes  No  Not sure/Maybe

16. Have you ever had hepatitis, jaundice or liver disease?  Yes  No  Not sure/Maybe

17. Do you have a bleeding problem or bleeding disorder?  Yes  No  Not sure/Maybe

18. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.  Yes  No

19. Do you have or have you ever had any of the following? Please check.
 chest pain, angina  pacemaker  diabetes  thyroid disease
 heart attack  lung disease  stomach ulcers  diet pill therapy
 stroke  tuberculosis  arthritis  drug/alcohol dependency
 shortness of breath  cancer  seizures (epilepsy)  sinus problems
 prosthetic heart valve  steroid therapy  kidney disease  undiagnosed rash/skin lesion

20. Are there any conditions or diseases not listed above that you have or have had? If so, what?  Yes  No  Not sure/Maybe

21. Are there any diseases or medical problems that run in your family?  Yes  No  Not sure/Maybe

22. Do you smoke or chew tobacco products?  Yes  No  Not sure/Maybe

23. Are you nervous during dental treatment?  Yes  No  Not sure/Maybe

24. Do you suffer from severe headaches? If so, how frequently?  Yes  No  Not Sure/Maybe

25. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?  Yes  No  Not sure/Maybe

26. Have you recently traveled outside of North America?  Yes  No

27. Have you recently been exposed to an infectious disease? (e.g. measles, chicken pox, tuberculosis)  Yes  No  Not sure/Maybe

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_