

ALPHA DENTAL CARE - FAX (403)-255-0438

Please fill in - print and fax or bring in to your appointment

PATIENT INFORMATION

Name: _____

Phone (Home): _____

Address: _____

(Work): _____

City / Province: _____

(Cell): _____

Postal Code: _____

E-mail: _____

Date of Birth: (Day/Month/Year) _____

Occupation: _____

Who referred you to our office? _____

POLICY OF THE OFFICE

Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that 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.

Date: _____ Signature: _____

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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 personal 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 routinely collect contact information from our patients such as names, home addresses, home telephone numbers, work phone numbers, and email addresses. Contact information may be used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, 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 need for further dental examinations or treatment.
- To send patients informational materials about our dental practice.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect medical information from our patients about personal health history, family health history, physical condition, and dental treatments. Patient medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patient Medical and Contact information may be disclosed:

- To third party health benefit providers and insurance companies when 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 their behalf.
- To other dentists and dental specialists, when the patient has given consent for a second opinion.
- To other health care professionals such as physicians, if the patient has consented to be 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 of its regulatory activities in the public interest.

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

Date

Print Name

Signature

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DENTAL HISTORY QUESTIONNAIRE

Name: _____

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

Root Canal Therapy

Bite adjusting appliance

Periodontics

Wisdom Teeth extracted

Partial or full dentures

Jaw Surgery

Crowns and Bridges

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 anesthetic or other drugs as indicated and will assume responsibility for fees associated with those procedures.

Date

Signature

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MEDICAL HISTORY QUESTIONNAIRE

Name: _____

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 _____ Not sure / Maybe

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 Not sure / Maybe

5. Do you have any allergies? If you answered yes, please list using the categories below:

Yes No Not sure / Maybe

a) Medications

b) Latex / rubber products

c) Other e.g. hay fever, foods

6. have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

Yes No Not sure / Maybe

7. Do you have or have you ever had asthma?

Yes No Not sure / Maybe

8. Do you have or have you ever had any heart or blood pressure problems?

Yes No Not sure / Maybe

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?

Yes No Not sure / Maybe

10. Do you have a prosthetic or artificial joint?

Yes No Not sure / Maybe

11. Have you ever been advised by your doctor to take antibiotics before dental treatment?

Yes No Not sure / Maybe

12. 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

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

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

15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
 Yes No Not sure / Maybe

16. Do you have or have you ever had any of the following? Please check.

<input type="checkbox"/> Chest pain, angina	<input type="checkbox"/> pacemaker	<input type="checkbox"/> diabetes	<input type="checkbox"/> thyroid disease
<input type="checkbox"/> heart attack	<input type="checkbox"/> lung disease	<input type="checkbox"/> stomach ulcers	<input type="checkbox"/> diet pill therapy
<input type="checkbox"/> stroke	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> arthritis	<input type="checkbox"/> drug/alcohol dependency
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> cancer	<input type="checkbox"/> seizures	<input type="checkbox"/> sinus problem
<input type="checkbox"/> prosthetic heart valve	<input type="checkbox"/> steroid therapy	<input type="checkbox"/> kidney disease	

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

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

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

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

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

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

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

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____