Located in the professional building by the food court; enter through the glass doors between Second Cup and Telus, then take the elevator up to the 5th floor

Alpha Dental Care

Suite 500, Chinook Professional Building
6455 Macleod Trail SW
Calgary, AB T2H 0K9

Phone: (403)252-7608 Fax: (403)255-0438
Email: teeth@alphadentalcare.com
www.alphadentalcare.com

First Name_____ Last Name_____

Preferred Name:_____

Address: *Unit #*_____ *Street* _____

City _____ *Province*_____ *Postal Code*_____

Phone *(Home)*_____*(Cell)*_____*(Work)*_____

Email_____

Date of Birth _____

(Day/Month/Year)

How were you referred to our office? _____

(Please be as specific as possible)

Alpha Dental Care Policy

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 cancellation fee may be 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 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 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 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 examination or treatment.**
- **To send patients information about our dental practice.**

Contact information is disclosed to the 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 cost of dental treatment, or has asked us to submit a claim on their 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, 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:

- **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 we are seeking a second opinion and the patient has consented that we obtain 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**

SNORING & SLEEP APNEA SCREENING FORM

1. Do you experience difficulty sleeping? ___Yes ___No

2. Do you wake during the night? ___Yes ___No ___Not Sure/Maybe

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

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)

	No	Yes
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 had any of the following treatments?

___ *Orthodontics*	___ *Root canal therapy*	___ *Splint / Night guard*
___ *Periodontics*	___ *Wisdom teeth extractions*	___ *Partial or full dentures*
___ *Jaw surgery*	___ *Crowns and bridges*	___ *Dental Implants*

PRESENT DENTAL CONCERNS

1. What dental problems concern you at present (if any)?_____
2. Do you have any of the following issues?

___ *teeth sensitive to heat, cold, pressure, sweets*	___ *Trigeminal Neuralgia*
___ *bad breath or bad taste in mouth*	___ *Vertigo (dizziness)*
___ *improper fitting dentures*	___ *Bell's Palsy*
___ *loose teeth*	___ *Tinnitus (ringing in ears)*
___ *gums that bleed when brushing or flossing*	___ *Dysphagia (difficulty swallowing)*
___ *Postural problems*	___ *Facial pain (non-specific)*
___ *Ear congestion*	___ *Difficulty chewing*

3. Are you unhappy 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 or severe headaches, migraines, dizziness, neck stiffness or ear problems?
   ___ *Yes* ___ *No* 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: _____

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 currently being treated, or have you been treated in the past year, for any medical condition?
   ___Yes ___No
   If yes, please explain: _____
2. When was your last medical check-up?_____
3. a) What is your height? _____ft _____in b) What is your weight? _____ lbs
4. Has there been any change in your general health in the past year?
   ___Yes ___No ___Not sure/Maybe
   If yes, please explain: _____
5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
   ___Yes ___No
   If yes, please list:_____
   _____

5. Do you have any allergies?
   a) Medications ___Yes ___No ___Not sure/Maybe
   b) Latex/rubber products ___Yes ___No ___Not sure/Maybe
   c) Other e.g. hay fever, foods ___Yes ___No ___Not sure/Maybe
   If yes, please list: _____
   _____
6. Have you ever had a peculiar or adverse reaction to any medicines or injections?
   ___Yes ___No ___Not sure/Maybe
   If yes, please explain: _____
7. Do you have or have you ever had asthma? ___Yes ___No ___Not sure/Maybe
8. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
   ___Yes ___No ___Not sure/Maybe
   If yes, please explain: _____

9. Do you have a prosthetic or artificial joint? ___Yes ___No

10. Have you ever been advised by your doctor to take antibiotics before dental treatment?
___Yes ___No ___Not sure/Maybe

11. Have you had any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ___Yes ___No ___Not sure/Maybe

12. Have you ever had hepatitis, jaundice or liver disease? ___Yes ___No ___Not sure/Maybe

13. Do you have a bleeding problem or bleeding disorder? ___Yes ___No ___Not sure/Maybe

14. Have you ever been hospitalized for any illnesses or operations?
___Yes ___No

If yes, please explain: _____

15. Do you have or have you ever had any of the following? Please check any that apply.

___*chest pain, angina*	___*pacemaker*	___*diabetes*	___*thyroid disease*
___*heart attack*	___*lung disease*	___*stomach ulcers*	___*diet therapy*
___*stroke*	___*tuberculosis*	___*arthritis*	___*drug/alcohol dependency*
___*high/low blood pressure*	___*cancer*	___*seizures(epilepsy)*	___*sinus problems*
___*prosthetic heart valve*	___*steroid therapy*	___*kidney disease*	___*undiagnosed rash/skin lesion*
___*persistent cough*	___*frequent diarrhea*	___*migraines*	___*Alzheimer's/dementia/*
___*parasthesia of fingertips*	___*anxiety*	___*shortness of breath*	*memory problems*

16. Are there any conditions or diseases not listed above that you currently have, or have had in the past?
___Yes ___No ___Not sure/Maybe

Please explain:_____

17. Are there any diseases or medical problems that run in your family?
___Yes ___No ___Not sure/Maybe

Please explain: _____

18. Do you smoke or chew tobacco products? ___Yes ___No

19. Have you recently traveled outside of North America? ___Yes ___No

If so, where and when?_____

20. Have you recently been exposed to an infectious disease (e.g. measles, chicken pox, tuberculosis)?
___Yes ___No ___Not sure/Maybe

If yes, please explain: _____

21. **(Women Only)**: Are you breast-feeding or pregnant? ___Yes ___No ___Not sure/Maybe

If pregnant, what is the expected delivery date?_____

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

Patient/Parent/Guardian Signature: _____**Date:** _____