Welcome to Our Dental Office

Our wish is to serve you better. This is why we ask that you complete this form to help expedite any future appointments and so that we get to know you better. This form will be issued on a regular basis for the purpose of updating our information as per the government guidelines. All information provided to our office is confidential and protected by P.I.P.E.D.A & P.H.I.P.A (Government mandated privacy policies) **PLEASE PRINT CLEARLY.**

PERSONAL INFORMATION

Last Name: _____ First Name: _____Pref Name_____

Your Address: _____ Suite # _____

City: _____ **Postal Code**: _____

Birthdate: Day _____ Mo_____ Yr_____ Marital Status _____ Gender: *Please Circle* M F Other
If other, identify: _____

E-Mail: _____ **Home Phone:** _____

Work: _____**Ext**:_____ **Cell :** _____

Best way to contact you: *Please check one:* Home Phone_____ Cell Phone_____ Email_____

Employer: _____ **Position:** _____

Driver's License#: _____ or Health Card _____
(This required for some prescriptions)

Emergency Contact: _____ Phone: _____ Relationship_____

How did you first hear about us, or who may we thank for referring you? (Please Circle)

Saw Sign **Family Comes Here** **Friend Comes Here (Name)** _____
Google **Facebook** **Website** **Yelp** **Other** _____

Do you speak any other languages? If so which ones? _____

INSURANCE INFORMATION

1. ***Your Insurance Company Name***: _____Div _____
   Employer Name: _____
   If there is an administrator their Name: _____
   Policy/Contract/Group #: _____ **Certificate/ID #:** _____
   Have you used any of your insurance benefits within this benefit year? _____
   If yes what was done and how long ago? _____

2. ***Your Spouse's Dental Benefits Information or Secondary Insurance (if applicable)***

Spouse Last Name: _____ First Name: _____ Birthdate: Day _____ Mo _____Yr ____
Employer: _____ Insurance Company: _____Div_____
Policy/Contract/Group #: _____ Certificate/ID #: _____
Have you used any of your insurance benefits within this benefit year? _____
If yes, what was done and how long ago? _____

Initial _____

Revised Jan 17, 2023 Form can be found in Shared Documents Folder under Office Forms, New Patient Medical History

MEDICAL HISTORY

Family Doctor Name: _____ Phone _____
Pharmacy Name: _____ Phone _____
Are you in good health? _____ Date of your last Physical? _____
Are you being treated for any medical condition at the present? Yes No If so what? _____
Please check if you have had or have any of the following conditions:

( ) Asthma
( ) Allergies _____
( ) Heart valve surgery/Pacemaker
( ) High Blood Pressure
( ) Bleeding disorder
( ) Cold Sore (Herpetic lesion)
( ) Aphthous ulcers (canker sore)
( ) Epilepsy (seizures)
( ) Smoker

( ) Diabetes
( ) Cholesterol
( ) Heart Attack
( ) Heart murmur
( ) Rheumatic fever
( ) Tuberculosis
( ) Hepatitis A/B/C
( ) Thyroid disease
( ) Chronic bronchitis

( ) Aids/HIV
( ) Cancer _____
( ) Liver problems
( ) Kidney problems
( ) Emphysema
( ) Prosthetic limb/organ
( ) Hypoglycemia
( ) Osteoporosis
( ) Arthritis

( ) Pregnant ___ weeks
( ) Stroke
( ) Hearing aid
( ) Other not listed:
_____
_____

Please **list any current medications**; including **over the counter and vitamins or naturopathic medications** (if you need additional space, please write on the back of this page):

Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____
Drug: _____ Dose: _____ Reason: _____

Please list any **allergies to Medicine**: _____
Did your doctor advice you to take any medication prior your dental appointment? YES NO. If Yes, drug name: _____

DENTAL HISTORY

Reason for this visit: _____
Date of most recent dental visit: _____ What was done at the time _____
Date of Last complete set of dental x-rays _____ Date of Last Hygiene Visit _____

What are you concerned about?

( ) Cavities
( ) Broken teeth
( ) Want to save teeth
( ) Gum disease
( ) Bleeding
( ) Recession
( ) Spacing
( ) Crooked teeth
( ) Whiter teeth
( ) Grinding / clenching
( ) Clicking Jaw
( ) Jaw pain
( ) Headaches
( ) Bad breath
( ) Cosmetic Dentistry

I see my dentist every: _____3 months' _____4 months' _____6 months' ____12 months' _____Not routinely (when I have pain)
How would you rate the condition of your mouth? _____Excellent _____Good _____Fair _____Poor

Does dental treatment make you nervous? *Please circle* No Slightly Moderately Extremely

We offer **Nitrous Oxide** to all our patients (laughing gas) to make you more comfortable during dental procedures. Would you be interested in having it during your dental procedures? ***Please circle*** YES NO

Please circle

Do you have bad breath? YES NO
Do your gums bleed? YES NO
Have you ever had local anesthetic (freezing?) YES NO
Do you understand the importance of regular hygiene? YES NO
Do your jaws hurt when you wake up? YES NO
Are you self-conscious of your smile? YES NO
Were there any complications? YES NO

If you could change anything about your smile, what would you change? _____

Have you ever had **Botox treatment** before? *Please circle* YES NO. If yes, what was the reason? *Please circle:* Cosmetic Therapeutic

Do you get "canker sores" or "cold sores" _____ how often do you get them? _____

When you look at your smile, is there anything – shape, alignment, or colour – you'd like to discuss?

Initial _____

We Would Like to Get to Know You Better...

I am changing my dentist because: (Circle any that Apply)

Recently moved to this Area	Dr/Staff Personality	Communication Problem	Inadequate Care
Fee Concern	Insurance	Second Opinion	Find a Dentist that understands me

I have avoided dental care in the past because: (Circle any that apply)

Fear of _____ Time Commitment _____ Trust Factor _____

Are you interested in? (Circle any that apply)

Smile Make Over Implants Sedation Invisalign Why Dental Infections Cause Heart & Other Diseases

Way to Reduce Periodontal Surgery Preventing Oral Cancer Home Care

Sleep Disorder Questionnaire

How likely are you to doze off or fall asleep n the following situations, in contrast to feeling just tired? (Use the following scale to choose the most appropriate number for each situation and circle any that apply)

Sitting and Reading Watching TV	Sitting inactive in a public place (theater or meeting)	Passenger in a car
Lying down to rest in the afternoon	Sitting and talking to someone	In Car while stopped in traffic

0-2 checks mean it is unlikely that you are abnormally sleepy
2-4 checks you may want to consider seeking medical attention
4+ you need to seek medical attention right away

I understand the above information is necessary to provide me with dental care in a safe manner. I have answered all the questions to the best of my knowledge. Should further information is needed; the office has my permission to ask the respective health care provider to release such information. I will notify the office and dentist of any change in my health or medication. I give authorization to the dentist to perform any treatment needed and to provide local anesthetic as is needed. I have reviewed the above information that explains how this office will use my personal information, and the steps your office is taking to protect my information. I agree that this dental office can collect, use, and disclose personal information about me as set out above

E-Mail and Text Message Consent: I acknowledge that I have given consent to receive reminder e-mails and /or text messages from this dental office.

Electronic Claim Submission Consent: I acknowledge that I have given consent to send my claims electronically directly to the insurance company on my behalf

Informed Consent for Dental Photography: With respect to all/any dental treatment, which I am receiving from this dental office l, I agree and consent to allow photographs taken before, during, and after completion of my treatment to be used for dental records, public relations, patient counseling or other purposes. I further agree and consent that the photographs relating to my dental care may be published and re-published, either separately or in connection with each other in dental photo albums, professional journals, dental books or digital media

Changing Appointments

We set aside reserved time in our office for meeting with you. If you find it necessary to change a reserved time, please provide 48 business hours' notice so that we may provide that appointment time to another patient in need of treatment or an emergency patient, or one of our patients on our waiting list.

Allowing us enough notice will avoid a charge of $100 on your accounts of a missed appointment.

Initial _____

P.I.P.E.D.A Privacy Legislation

Office Policy & Important Information Regarding Your Dental Insurance

At our office, we are committed to providing you with the best care possible for your personal wellbeing. If you have dental insurance, we will help you receive your maximum allowable benefit, in order to achieve these goals, we need your assistance and your understanding of our financial policy. We accept cash, Master Card, Visa, American Express and Debit Cards. NO CHEQUES. Outstanding balances older than 45 days may be subject to finance charges at the monthly rate of 1.5%. If you have dental insurance, you must bring proof of insurance and we will be more than happy to submit your insurance claims for you. We will also help you to collect the information from the insurance company. However, you must realize:

1. Your insurance is a contract between you, your employer, and the insurance company. Therefore, we are not a party to that contract.
2. We cannot render services on the assumption that the charges will be paid for by an insurance company. All charges are your responsibility from the date the services are rendered.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Remember to update our office and staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.

I agree to abide by the terms outlined. I understand and accept my financial responsibilities

For Collection, Use and Disclosure of Personal Information

The privacy of your personal information is important part of our office providing you with quality dental care. We are committed to collecting, using and disclosing your personal information with responsibility. Our team members are trained in the appropriate uses and protection of your information.

Our Dental Office will collect, use and disclose information about you for the following purposes:

- To Identify and to ensure continuous high quality service
- To offer and provide treatment, care and services in relationship to the dental care
- To communicate with other treating health-care providers, specialists and general dentists
- To allow us to maintain communication with you, to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- To comply with legal and regulatory requirements in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- To deliver your charts and records to the dentist`s insurance carrier to enable the insurance company to assess liability and quantify damages
- To process credit card payments and to collect unpaid accounts
- To assist this office to comply with all regulatory requirements and the law

I agree and consent to have this form, and all my records shared between Dentistry at Momentum, Alderwood Family Dentistry and/or The Stockyards Dental in case I am referred there for any dental assessment or treatment going forward.

Patient Name _____ Patient Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

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