Date: _____

SOUTHBROOK DENTAL GROUP

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form.

PLEASE PRINT

Registration information

Name:_____
First Middle Last Preferred

Address:_____
Street Apt # City Province Postal Code

Daytime Phone: _____ Bus Phone: _____ Cell Phone: _____

Email: (required for appointment reminders/confirmations)
_____

Reason for today's visit? Examination □ Other □ _____

Personal Information

Date of Birth: D _____/M_____/Y_____ Age: _____ Marital Status: _____ Name of Spouse:_____

Alberta Health Care Number: _____

Are other family member's patients at our office: Yes □ No □ If so, names: _____

How did you hear about our office? Friend/Relative □ Google □ Advertising □ Other □ _____

Whom may we thank for referring you? _____

Emergency Contact: _____Relationship:_____ Phone: _____

Financial Information- ***please complete all information if different than above***

Driver's License or SIN Number:_____

Person responsible for account: Self □ Spouse □ Other □

Name: _____

Employer Information:_____

Date:_____ Name:_____

Medical History - Please answer YES or NO to each question. ***If unsure of a question, please consult with dentist or receptionist.***

1. Have you been hospitalized, treated for a medical condition or had there been any change in your general health?- _____

2. When was your last medical checkup? _____

Family Physician: _____ Phone: _____

Medical Specialist: _____ Phone: _____

3. Have you recently, or are you presently taking any **PRESCRIPTION** or **NON-PRESCRIPTION** drugs? Please list:
1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

4. Have you ever reacted adversely to any of the following or been advised against taking a specific medication? Please circle
PENICILLIN, KEFLEX, DALACIN, SULFA, ASPRIN, VALIUM, CODIENE, NARCOTICS, LOCAL ANAETHETIC (freezing)
Other medicines not listed: _____
Are there any other allergies we should be aware of? For example – Metal or latex _____
5. Have you been advised by your medical doctor or dentist to take antibiotics prior to dental treatment? _____
If yes, please explain: _____
6. Do you have a bleeding problem or bleeding disorder: _____
7. Do you smoke or use any other forms of tobacco / medical marijuana and or vaping?_____

Please CIRCLE which of the following you presently have or ever had:

AIDS	Yes No	Glandular Disorders	Yes No	Latex Allergy	Yes No
Anemia	Yes No	Head/Neck Injuries	Yes No	Liver Disease	Yes No
Angina Pectoris	Yes No	Heart murmur	Yes No	Metal Allergy	Yes No
Arthritis/Rheumatism	Yes No	Heart Pacemaker	Yes No	Mitral valve prolapse	Yes No
Artificial Heart Valve	Yes No	Heart Rhythm Disorder	Yes No	Organ transplant/ medical implant	Yes No
Artificial Joints (hip, knee)	Yes No	Heart Surgery	Yes No	Psychiatric Treatment	Yes No
Blood Disorder	Yes No	Hepatitis A	Yes No	Radiation treatment/chemotherapy	Yes No
Bronchitis	Yes No	Hepatitis B	Yes No	Rheumatic/Scarlet Fever	Yes No
Cancer	Yes No	Hepatitis C	Yes No	Sickle Cell Disease	Yes No
Circulation Problems	Yes No	HIV	Yes No	Sinus Trouble	Yes No
Congenital Heart Lesions	Yes No	High Blood Pressure	Yes No	Stomach/intestinal problems	Yes No
Cortisone/ Steroids	Yes No	Low Blood Pressure	Yes No	Stroke	Yes No
Diabetes	Yes No	Hodgkins Disease	Yes No	Hyperthyroid	Yes No
Emphysema	Yes No	Hyper (hypo) Glycemia	Yes No	Hypothyroid	Yes No
Epilepsy/Seizures	Yes No	Jaundice	Yes No	Tuberculosis	Yes No
Fainting/ Dizzy Spells	Yes No	Kidney Disease	Yes No	Other	Yes No

8. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? _____

9. Do you wish to speak to a dentist privately about any problem or medical conditions? _____

10. **Woman Only:** Are you pregnant or suspect you may be? _____

If yes, what is the expected delivery date? _____ Are you taking birth control?_____

Date:_____ Name:_____

Dental History- Please indicate YES or NO to each question. If unsure of a question, please consult with the dentist or receptionist.

1. Is there a dental problem you would like treated immediately? Yes □ Problem:_____

2. Date of last dental visit?_____ Last dental cleaning?_____ Last x-rays?_____

3. Have you ever had any of the following?

Periodontal Treatment (treatment to the gums)	Yes □ No □	Bite plate, night guard, or any other appliance?	Yes □ No □
Dentures or partial denture	Yes □ No □		
Orthodontic treatment (treatment to realign teeth)	Yes □ No □		
Wisdom teeth removal	Yes □ No □		

4. Are there any growth or sore spots in your mouth? Yes □ No □
5. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? Yes □ No □
6. Have you noticed any loose teeth, or have any of your teeth shifted? Yes □ No □
7. Does food catch between your teeth? Yes □ No □
8. Are any of your teeth sensitive to heat, cold, sweets or pressure? Yes □ No □
9. Are you aware of clenching or grinding your teeth while awake or asleep? Yes □ No □
   - Popping/clicking in your jaw joints? Yes □ No □
   - Pain in your jaw joints, around your ear or side of your face Yes □ No □
   - Difficulty in opening or closing? Yes □ No □
   - Do you suffer from frequent headaches? Yes □ No □
10. Are you happy with the appearance of your teeth? Yes □ No □
    If not, what would you like to see changed? (For example straighter / whiter teeth) _____
11. Have you ever had an upsetting experience at a dental office?

_____

APPOINTMENTS

Please help us maintain the operation of our office on sound principle 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. Failure to no show for a reserved appointment or cancellation short notice will result in a $50.00 no show fee.

□ **Initial**

PAYMENT OF FEES

Two payment options available.

1. **Non-assignment** – Our office completes the claim form and mails directly to insurance company who pay patient directly.
2. **Assignment –** Our office direct bills insurance company and patient is responsible for any difference or fees not covered by their insurance.

□ **Initial**

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and personal and medical-dental history and have not knowingly omitted any information. I also authorized the communication of information related to the coverage of services described in this form to the named doctor.

□ **Initial**

CONSENT

I, the undersigned, hereby authorize the doctor to take x-ray, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy, that may indicated and consent to the use of local anaesthetic agents. I understand the about statements regarding the payment of fees and accept the responsibility for payment for dental services provided for myself of my dependants, due and payable when services are rendered unless other financial arrangements have been made.

□ **Initial**

Patient Signature: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to Patient: _____