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 where we follow privacy protocols to safeguard your information. 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)
____

Do you consent to receive e-mailed educational or promotional material? Yes/No
Signature: _____________________________________

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: _________________________________ Gender: ___________________________

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 □ ______________________

If you were referred by a Friend/Relative, whom may we thank for referring you? _____________________________

Emergency Contact: _____________________Relationship:_______________ Phone: ________________

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

Person responsible for account: Self □ Spouse □ Other □

Name: ____

Employer : ____

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 has there been any change in your general health? ____
____

2. When was your last medical checkup? ____

Date:______________________ Name:_________________________________

Family Physician: ________________________________ Phone: ________________________

Medical Specialist: _______________________________ Phone: ________________________

Pharmacy/Pharmacist: _____________________________ 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, CLINDAMYCIN, SULFA, ASPIRIN, VALIUM, CODEINE, NARCOTICS, LOCAL ANAESTHETIC (freezing), ANTI-INFLAMMATORIES, MILK
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 (not related to an infection) prior to dental treatment? Yes □ No □ If yes, please explain: ____

6. Do you smoke, vape, or use any other forms of tobacco/marijuana? Yes □ No □ If yes, please explain: _________________

Would you like to discuss your options for quitting? Yes □ No □

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

AIDS	Yes No	Epilepsy/Seizures	Yes No	Hyperthyroid	Yes No
Anemia	Yes No	Fainting/ Dizzy Spells	Yes No	Hypothyroid	Yes No
Angina Pectoris	Yes No	Glandular Disorders	Yes No	Kidney Disease/ Dialysis	Yes No
Arthritis/Rheumatism	Yes No	Head/Neck Injuries	Yes No	Liver Disease	Yes No
Artificial Heart Valve	Yes No	Heart murmur	Yes No	Lupus	Yes No
Anxiety	Yes No	Heart Pacemaker	Yes No	Mitral valve prolapse	Yes No
Artificial Joints (hip, knee)	Yes No	Heart Rhythm Disorder	Yes No	Neuralgia	Yes No
Asthma	Yes No	Heart Attack ____/____(MM/YY)	Yes No	Organ transplant/ medical implant	Yes No
Blood Disorder	Yes No	Heart Surgery	Yes No	Osteoporosis	Yes No
Cancer	Yes No	Hemophelia	Yes No	Psychiatric Treatment	Yes No
Circulation Problems	Yes No	Hepatitis A	Yes No	Radiation treatment/chemotherapy	Yes No
Congenital Heart Lesions	Yes No	Hepatitis B	Yes No	Rheumatic/Scarlet Fever	Yes No
Cortisone/ Steroid Treaments	Yes No	Hepatitis C	Yes No	Sickle Cell Anemia	Yes No
Crohn's/Colitis	Yes No	HIV	Yes No	Sinus Trouble	Yes No
Depression	Yes No	High Blood Pressure	Yes No	Stomach/intestinal problems	Yes No
Diabetes	Yes No	Low Blood Pressure	Yes No	Stroke ____/____(MM/YY)	Yes No
Dry Mouth	Yes No	Hodgkins Disease	Yes No	Tuberculosis	Yes No
Emphysema	Yes No	Hyper (hypo) Glycemia	Yes No	Other: ________________	Yes No

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

8. 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 □	Orthodontic treatment (to realign teeth)	Yes □	No □
Dentures or partial denture	Yes □	No □	Root canal treatment	Yes □	No □
Bite plate, night guard, retainers, or any other appliance?	Yes □	No □	Do you snore, wear a snore guard or CPAP machine?	Yes □	No □
Wisdom teeth removal	Yes □	No □	Dental Implants	Yes □	No □

4. Are there any growth or sore spots in your mouth? Yes □ No □
5. Have you previously noticed, or been told you may be cavity prone? Yes □ No □
6. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? Yes □ No □
7. Are any of your teeth sensitive to heat, cold, sweets or pressure? (If yes, circle which one) Yes □ No □
8. Have you had trauma to your teeth or mouth? Briefly describe: ________________________________ Yes □ No □
9. Have you noticed any loose teeth, or have any of your teeth shifted? Yes □ No □
10. Have you fractured or cracked any teeth? Yes □ No □
11. Does food catch between your teeth? Yes □ No □
12. Please indicate how often you floss your teeth: Daily Twice/Week Weekly Monthly Annually Never
13. Which toothpaste do you use? ____
14. 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 □
15. If you suffer from temporomandibular (TMD/jaw) pain what have you tried to manage it?
    Botox Splint Night guard Retainer Massage Chiropractor Physiotherapy
16. How would you rate your smile with 1 being the lowest, and 10 being the highest rating? 1 2 3 4 5 6 7 8 9 10
17. What are your goals for your teeth? Comfort Function/Chew Better Health Longevity Cosmetic Straighter Whiter
18. 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 provide cancellation notice, or come to a reserved appointment 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, mails it directly to the insurance company who then pays the patient directly.
2. **Assignment –** Our office direct bills the insurance company and the patient is responsible for any difference or fees not covered by their insurance. Fees are due and payable on the day of your appointment unless other financial arrangements have been made. **Initial: _______**

GENERAL RELEASE
I, the undersigned, certify that I have provided an accurate and complete 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 consent or authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of dental needs. I consent and authorize the doctor to perform any and all forms of tests, treatment, medication and therapy that may indicate the use of local anaesthetic (freezing) agents. I understand the above statements regarding the payment of fees. I accept the responsibility of payment for dental services provided to myself and/or my dependants. **Initial: _______**

Patient Signature: ______________________________ Date: ______________________________ Witness: ____________________

Parent or Responsible Party: ______________________________ Relationship to Patient: ______________________________