edgemont dental care

Patient Information

Name: _____ **Preferred Name:**_____ **Date of birth:**_____
Address: _____ **City:** _____ **Prov:** _____ **Postal Code:** _____
Home phone: _____ **Cell phone:** _____ **Work phone:** _____
Preferred contact number: H / C / W **Email:** _____ **How did you hear about us?** _____
Do you consent to email reminders? YES / NO **Text reminders?** YES / NO **Newsletters?** YES / NO **In-office promotions?** YES / NO
Emergency Contact: _____ **Phone:** _____
Do you have dental insurance? YES / NO

Person responsible for account/Responsible party: (If different from above):
Name: _____ **Phone:** _____ **Relationship to patient:** _____
Address: _____ **City:** _____ **Prov:** _____ **Postal Code:** _____

OFFICE POLICIES, PATIENT PRIVACY AND CONSENT FORM

APPOINTMENTS
Once you have made an appointment, this time is reserved for you. If cancellation is absolutely necessary, at least **2 BUSINESS DAYS NOTICE** must be given, so that we may assure uninterrupted treatment for you and other patients. If adequate notice is not given, a cancellation fee may be assessed to your account.

PAYMENT OF FEES
1. This office does not accept direct payment from your dental plan. You are responsible for paying the full cost of your treatment.
2. We will submit your claim to your dental plan, which can reimburse you within 28-48 hours.
3. You are responsible for providing the necessary information for us to communicate with your dental plan.
4. You are responsible for registering for direct bank deposit with your dental plan so that you can be reimbursed directly from your dental plan.

PATIENT PRIVACY AND CONSENT
Due to the new Government of Canada rules and regulations under the Freedom of Information and Privacy Act, we require all current and new patients to sign the following consent form. Maintaining the privacy of your personal information is integral to our office.

We are committed to collecting, using and disclosing your personal information in a responsible manner to ensure that our office complies with the provincial privacy legislation in force.

Our office collects personal information from patients required for the safe and efficient delivery of dental treatment, including information used for payment of dental service, and to communicate with other treating health care providers; including specialists and referring doctors. This information will be retained only as long as necessary to fulfill these purposes or as required by law. Our office takes reasonable steps to ensure the personal information under our control is protected from unauthorized use and disclosure. When it is no longer required, all personal information is destroyed prior to disposal.

CONSENT
I hereby authorize the doctor to take x-rays, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I authorize the doctor to perform any and all forms of treatment, medicaton and therapy, that may be indicated and consent to the use of local anesthetic agents. However, I reserve the right to refuse one or any of the above recommended forms of treatment.

I understand the above statements regarding payment of fees and accept the responsibility for payment for dental services provide for myself or my dependents, due and payable when services are rendered unless other financial arrangements have been made.

Patient Signature (parent or guardian if minor): _____ **Date:** _____

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Medical History

Name: _____
Date of birth: _____
Family Doctor's name: _____
Purpose of doctor visit: _____ **Date of most recent doctor visit:** _____

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	□	□
2. an allergic reaction to		
☐ aspirin		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems_____	□	□
4. history of infective endocarditis_____	□	□
5. artificial heart valve, repaired heart defect_____	□	□
6. pacemaker or implantable defibrillator _____	□	□
7. orthopedic implant (joint replacement)_____	□	□
8. rheumatic or scarlet fever_____	□	□
9. high or low blood pressure_____	□	□
10. a stroke (taking blood thinners) _____	□	□
11. anemia or other blood disorder _____	□	□
12. prolonged bleeding due to a slight cut (INR>3.5)_____	□	□
13. emphysema, shortness of breath, sarcoidosis_____	□	□
14. tuberculosis_____	□	□
15. asthma_____	□	□
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus issues)_____	□	□
17. kidney disease_____	□	□
18. liver disease_____	□	□
19. jaundice_____	□	□
20. thyroid, parathyroid disease_____	□	□
21. hormone deficiency _____	□	□
22. high cholesterol or taking statin drugs_____	□	□
23. diabetes (HbA1c=_____)_____	□	□
24. stomach or duodenal ulcer_____	□	□
25. digestive disorders (e.g. celiac disease, reflux)_____	□	□

	YES	NO
26. osteoporosis/osteopenia (i.e.taking bisphosphonates)_____	□	□
27.arthritis_____	□	□
28. autoimmune disease (e.g. rheumatoid arthritis, lupus)_____	□	□
29. glaucoma_____	□	□
30. head or neck injuries_____	□	□
31. epilepsy or seizures_____	□	□
32. neurologic disorder (e.g. ADHD, dementia)_____	□	□
33. cold sores_____	□	□
34. any lumps/swelling in the mouth_____	□	□
35. hives, skin rash, hay fever_____	□	□
36. hepatitis (type___) _____	□	□
37. HIV/AIDS _____	□	□
38. tumor, abnormal growth _____	□	□
39. radiation therapy_____	□	□
40. chemotherapy_____	□	□
41. immunosuppressive medication_____	□	□
42. emotional difficulties _____	□	□
43. psychiatric treatment _____	□	□
44. antidepressant medication_____	□	□
45. alcohol use_____	□	□
46. recreational drug use _____	□	□
ARE YOU:		
47. presently being treated for any other illness_____	□	□
48. aware of a change in your health in the last 24 hours (i.e. fever, cold, diarrhea) _____	□	□
49. taking medication for weight management_____	□	□
50. taking dietary supplements_____	□	□
51. often exhausted or fatigued _____	□	□
52. experiencing frequent headaches _____	□	□
53. a smoker or smoked previously_____	□	□
54. considered a sensitive person _____	□	□
55. often unhappy or depressed_____	□	□
56. FEMALE – taking birth control pills_____	□	□
57. FEMALE – pregnant or breast-feeding _____	□	□
58. MALE – prostate disorders _____	□	□

Describe any current medical condition, impending surgery, or other treatment not listed above: _____

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____

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Dental History

Name: _____

Date of birth: _____

Name of Previous Dentist: _____ **How long were you a patient of this office?**_____

Frequency of dental visits: □ 3 mo. □ 4 mo. □ 6 mo. □ 12 mo. □ Not Routinely

What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? If so, how fearful, low, medium, or high? _____	□	□
2. Have you had an unfavourable dental experience? _____	□	□
3. Have you ever had complications from past dental treatment? _____	□	□
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	□	□
5. Did you ever have orthodontic treatment (e.g. braces, aligners, retainer)? _____	□	□
6. Have you had any teeth removed (including wisdom teeth)? _____	□	□
GUM AND BONE		
7. Do your gums bleed when brushing or flossing?_____	□	□
8. Have you ever been treated for gum disease or lost bone around your teeth? _____	□	□
9. Have you ever experienced gum recession?_____	□	□
10. Have you ever had gum grafting? _____	□	□
11. Is there anyone with a history of gum disease in your family?_____	□	□
12. Have you ever had any teeth become loose?_____	□	□
13. Have you experienced a burning sensation in your mouth? _____	□	□
TOOTH STRUCTURE		
14. Have you had any cavities within the last 3 years?_____	□	□
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?_____	□	□
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?_____	□	□
17. Are any teeth sensitive to cold, hot, biting, sweets, or avoid brushing in any part of your mouth?_____	□	□
18. Do you have any grooves or notches on your teeth near the gumline? _____	□	□
19. Do you have broken teeth, chipped teeth, or had a toothache or cracked filling?_____	□	□
20. Do you frequently get food caught between any teeth in particular? _____	□	□
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking) _____	□	□
22. Do you feel like you contact your front teeth before your back teeth when you bite together?_____	□	□
23. Do you have difficulty chewing hard foods (e.g. nuts)? _____	□	□
24. Have your teeth changed become more worn in the last 5 years? _____	□	□
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	□	□
26. Are your teeth developing spaces or becoming loose? _____	□	□
27. Do you have more than one bite, or squeeze/shift your jaw to make your teeth fit together? _____	□	□
28. Do you place your tongue between your upper and lower teeth?_____	□	□
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	□	□
30. Do you clench your teeth in the daytime? _____	□	□
31. Do you clench your teeth at night time? Or wake up with a headache/sore teeth? _____	□	□
32. Have you ever had a nightguard for grinding your teeth? _____	□	□
SMILE/FACIAL CHARACTERISTICS		
33. Is there anything about the appearance of your teeth you would like to change?_____	□	□
34. Have you been disappointed with the appearance of previous dental work?_____	□	□
35. Do you have any interest in tooth whitening? _____	□	□
36. Do you have any interest in Botox or facial fillers? _____	□	□

Patient's Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____