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

Please help us maintain the operation of our office so that we may assure uninterrupted treatment for you and other patients. Remember that once you have made an appointment, this time is *reserved for you.* Therefore, at least 2 BUSINESS DAYS NOTICE must be given if cancellation is absolutely necessary. If adequate notice is not given, a cancellation fee may be assessed to your account.

PAYMENT OF FEES

1. This office is willing to accept direct payment from your dental plan for services which your plan covers.
2. If your dental plan does not cover the full cost of your treatment, you will be responsible for the difference between the amount paid by your plan and the amount charged by our office.
3. Your portion is due and payable on the day of your appointment unless other financial arrangements have been made.
4. You are responsible for providing the necessary information in order for us to directly bill your insurance company as well as informing us of any changes in this information.

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.

To ensure accuracy of personal information, our office encourages patients and staff to maintain records that are accurate and up to date. Patients can notify our staff on their next visit, or contact the office if there is a change in any relevant information. For more information on our policies, or should you have any concerns regarding your personal information, please contact our office.

To further ensure that we have no difficulties in communicating with your insurance company or other doctors, we require that you sign this form to consent the release of your personal information.

CONSENT

I, the undersigned, hereby 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 my dental needs. I authorize the doctor to perform any and all forms of treatment, medication 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: _____
Physician Name: _____ **Date of most recent doctor visit:** _____
Purpose of 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 (i.e. celiac disease, gastric reflux)_____	□	□

	YES	**NO**
26. osteoporosis/osteopenia (i.e.taking bisphosphonates)_____	□	□
27.arthritis_____	□	□
28. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma)_____	□	□
29. glaucoma_____	□	□
30. head or neck injuries_____	□	□
31. epilepsy or seizures_____	□	□
32. neurologic disorder (ADD/ADHD, prion disease) _____	□	□
33. cold sores_____	□	□
34. any lumps/swelling in the mouth_____	□	□
35. hives, skin rash, hay fever_____	□	□
36. STI/STD/HPV_____	□	□
37. hepatitis (type___) _____	□	□
38. HIV/AIDS _____	□	□
39. tumor, abnormal growth _____	□	□
40. radiation therapy_____	□	□
41. chemotherapy, 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, smoked previously or use smokeless tobacco____	□	□
54. considered a touchy/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? How fearful, on a scale of 1(least) to 10(most) [_____]_____	□	□
2. Have you had an unfavorable 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 braces, orthodontic treatment or had your bite adjusted? _____	□	□
6. Have you had any teeth removed?_____	□	□
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?_____	□	□
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	□	□
9. Have you ever noticed an unpleasant taste or odor in your mouth?_____	□	□
10. Is there anyone with a history of periodontal disease in your family?_____	□	□
11. Have you ever experienced gum recession?_____	□	□
12. Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple?_____	□	□
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 hot, cold, 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? _____	□	□
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking) _____	□	□
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?_____	□	□
23. Do you have difficulty chewing hard foods, such as carrots, nuts, bagels, etc.? _____	□	□
24. Have your teeth changed in the last 5 years, become shorter, thinner, or worn? _____	□	□
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 teeth or close your teeth against your tongue?_____	□	□
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 or make them sore? _____	□	□
31. Do you wake up with a headache or an awareness of your teeth?_____	□	□
32. Do you wear or have you ever worn a nightguard? _____	□	□
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth you would like to change?_____	□	□
34. Have you ever whitened (bleached) or teeth? _____	□	□
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?_____	□	□
36. Have you been disappointed with the appearance of previous dental work?_____	□	□

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

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