MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:

1. hospitalization for illness or injury _____ ☐
2. an allergic or bad reaction to any of the following:
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erthromycin
   - ☐ tetracycline
   - ☐ sulfa
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals latex
   - ☐ nuts
   - ☐ fruit
   - ☐ milk
   - ☐ other
3. heart problems, or cardiac stent within the last six months ☐
4. history of infective endocarditis ☐
5. artificial heart valve, repaired heart defect (PFO) ☐
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. pneumonia, emphysema, shortness of breath, sarcoidosis ☐
14. tuberculosis, measles, chicken pox ☐
15. asthma ☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) ☐
17. kidney disease ☐
18. liver disease ☐
19. jaundice ☐
20. thyroid, parathyroid disease, or calcium deficiency ☐
21. hormone deficiency ☐
22. high cholesterol or taking statin drugs ☐
23. diabetes (HbA1c = _____) ☐
24. stomach or duodenal ulcer ☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) ☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ☐
27. arthritis ☐
28. autoimmune disease (i.e. rheumatoid arthritis, lupus, scleroderma) ☐
29. glaucoma ☐
30. contact lenses ☐
31. head or neck injuries ☐
32. epilepsy, convulsions (seizures) ☐
33. neurologic disorders (ADD/ADHD, prion disease) ☐
34. viral infections and cold sores ☐
35. any lumps or swelling in the mouth ☐
36. hives, skin rash, hay fever ☐
37. STI/STD/HPV ☐
38. hepatitis (type ____) ☐
39. HIV/AIDS ☐
40. tumor, abnormal growth ☐
41. radiation therapy ☐
42. chemotherapy, immunosuppressive medication ☐
43. emotional difficulties ☐
44. psychiatric treatment ☐
45. antidepressant medication ☐
46. alcohol/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, chills, new cough, or 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. taking birth control pills ☐
57. currently pregnant ☐
58. diagnosed with a prostate disorder ☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

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.

Springbank DENTAL CENTRE

116-30 Springborough Boulevard SW
Calgary, Alberta T3H 0N9
(403) 277-7464
www.springbankdental.ca

DENTAL HISTORY

WHAT IS YOUR IMMEDIATE CONCERN? _____

		YES	NO
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, and at what age?	☐	☐
6.	Have you had any teeth removed or missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
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 an injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
14.	Have you had any cavities within the past 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 do you avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you bite your back teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner or worn) or has your bite changed?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or 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 or grind your teeth together in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐
33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	☐	☐
34.	Have you ever whitened (bleached) your 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?	☐	☐
37.	What do you want your teeth to be like in 20 years? _____		

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Springbank
DENTAL CENTRE

Dental Office Personal Information Consent Form

We are committed to protecting the privacy of our patient's personal information and to utilizing all personal information in a responsible manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home and work addresses, home and work telephone numbers, and e-mail addresses. (Collectively known as "Contact Information") Contact information is collected and used for the following purposes:

- To open up and update patient files.
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment.
- To send patients information material about our dental practice.

Contact information is disclosed to third-party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patients' behalf.

Financial information may be collected in order to make arrangement for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition and previous dental treatments. (Collectively known as "Medical Information") Patients' Medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical information is disclosed:

- To third-party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patients' behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to obtaining a second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- To other health professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

If we are ever considering selling all or part of our dental practice, qualified purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclose of my personal information as set out above.

Agreed and accepted on this date

_____

Signature of Patient

Springbank
DENTAL CENTRE

Office Policies of Insurance Policies

Springbank Dental Centre ("Springbank") is hereby authorized to maintain the "Patient(s)" financial information in its records in order to make arrangements for payment of dental services from the Patient's benefits provider(s). Springbank accepts assignment of dental benefits for the Patient's convenience. Springbank requires that the Patient provide valid and current credit card information to be maintained on the Patient's file. Springbank agrees not to disclose credit card information to third parties or to use credit card information unless authorized by the Patient to do so. The patient hereby agrees that amounts owing after payment of insurance benefits will be charged to the Patient's credit card unless alternate arrangements are made and agreed to by both Parties.

With regard to dental health benefit plans, it should be realized that the plan is between the benefits company and the employee (i.e. patient) and as such the details of coverage are unknown to Springbank.

When an estimate is requested, Springbank will be as accurate as possible. Unfortunately, dental treatment complications cannot be entirely foreseen and hence differences between estimates and actual costs can arise. Once again, the difference will be the responsibility of the account holder.

***If it becomes necessary to cancel an appointment, I understand that 48 hours notice is required for cancellation of that appointment. There will be a $75 charge for missed appointments which will immediately be charged to my credit card without further notice. If I no-show for 3 appointments, I will be dismissed from the practice.

Initial

☐

Agreed and accepted on this date _____

_____

Signature of Patient

Who may we contact in case of emergency: _____ (Name)

_____ (Telephone Number)

How did you hear about our office? _____