Albany DENTAL

YOUR HEALTH, YOUR SMILE, OUR COMMITMENT

Patient Information

Title (Circle one) Mr. Mrs. Ms. Dr. Marital Status _____ Male ☐ Female ☐

Name: First _____ Initial _____ Last _____

Preferred Name _____ Date of Birth (DD/MM/YYYY) _____/_____/_____

Address _____

City_____ Province _____ Postal Code _____

Employer/School _____ Occupation _____

Phone H (_____) _____ W (_____) _____ C (_____) _____

Email_____ How did you hear about our office?_ _____

Physician Name _____ Telephone Number _____

Alberta Health Care# _____

Emergency Contact _____ Telephone Number _____

Insurance Information

Primary Insurance Company _____ Secondary Insurance Company _____

Policy Holder Name _____ Policy Holder Name _____

Date of Birth (DD/MM/YYYY)_____/_____/_____ Date of Birth (DD/MM/YYYY) _____/_____/_____

Group/Policy/Plan # _____ Group/Policy/Plan # _____

I.D./Certificate # _____ I.D./Certificate # _____

Relationship to Patient _____ Relationship to Patient _____

Medical History

1. Have you ever had a serious illness or condition requiring hospitalization or extensive medical care?
   If Yes, Please Specify
   _____
2. Are you currently under the care of a physician?
   Please Specify
3. _____
   Do you take any prescription or non-prescription drugs regularly?
4. Please specify _____
   Do you take any **BLOOD THINNERS**? ☐ Yes ☐ No Please specify_____
   Have you ever experienced unusual reactions to any of the following?
5. ☐ Penicillin ☐ Local Anesthetic ☐ Aspirin ☐ Codeine ☐ Sulpha Drugs ☐ Latex ☐ Other
6. Please explain _____
   Do you have AIDS or have you ever tested positive for H.I.V.? _____
   Have you ever had an injury, surgery, or radiation therapy to your head, face, jaw, or neck?
7. If Yes, Please Specify_____

Women only: Are you currently pregnant or suspect you might be?

If so, how many weeks? _____ Are you nursing? YES ☐ NO ☐

8. Have you had any organ transplants or medical implants? YES ☐ NO ☐

9. Do you experience shortness of breath or chest pain when walking or climbing stairs? YES ☐ NO ☐

PLEASE COMPLETE REVERSE SIDE

Do you currently experience, or have you ever had any of the following? Please check/circle all that apply:

☐ Angina	☐ Drug/Alcohol Dependency	☐ Hyper/ Hypo Glycemia	☐ Sinus Problems
☐ Arthritis/ Rheumatism	☐ Epilepsy/Seizures	☐ High/Low Blood Pressure	☐ Stomach Problems/ Ulcers
☐ Asthma	☐ Fainting	☐ Joint Replacement	☐ Stroke
☐ Blood Thinners	☐ Frequent Headaches	☐ Kidney Problems	☐ Swelling of Ankles
☐ Bruise Easily	☐ Glaucoma	☐ Liver Disease	☐ Thyroid Disorder
☐ Cancer/ Chemotherapy	☐ Heart Disease	☐Lung Disease/Emphysema	☐ Tuberculosis
☐ Cold Sores	☐ Heart Murmur	☐ Mental/Nervous Disorder	☐ _____
☐ Cortisone/Steroid Therapy	☐ Hepatitis A/B/C	☐ Sexually Transmitted Disease	☐ _____

Please elaborate on any of the above:

_____

_____

Previous Dental History

1. Former Dentist _____ Last Visit Date _____
2. Do you have a specific concern you would like addressed?
   If Yes, Please describe _____
3. How often do you brush your teeth? _____
4. How often do you floss your teeth? _____
5. Are your teeth sensitive to: Hot ☐ Cold ☐ Sweets ☐ Biting and/or chewing ☐
6. Do your gums bleed easily? YES ☐ NO ☐
7. Are you aware of an unpleasant taste in your mouth or bad breath? YES ☐ NO ☐
8. Do you smoke?
   If Yes, How many years have you smoked? _____ How many per day? _____
9. Do you experience any tightness, clicking or pain in the jaw joint? YES ☐ NO☐
10. Do you clench or grind your teeth? YES ☐ NO ☐
11. Do you bite your nails or suck your thumbs or fingers? YES ☐ NO ☐
12. What cosmetic changes would you make to your teeth?
    Straighten ☐ Whiten ☐ Improve Shape ☐ Other ☐ _____
13. If you recently had surgery or will be having surgery, do you require premedication for dental treatment?
    Please Specify type of surgery _____
14. On a scale of 1 to 5 how nervous do you feel coming to the dentist? NOT AT ALL 1 2 3 4 5 VERY

I certify that I have provided an accurate and complete personal and medical/dental history to Aspira Dental and have not knowingly mislead or omitted any information. I have had the opportunity to ask questions and fully understand all of the questions on this form. I authorize the dentist to perform diagnostic procedures and treatment as necessary for proper dental care. I understand that consultation with my medical doctor may be required and I consent to my physician being contacted if

necessary. I authorize the free exchange of information between Aspira Dental and my dental insurance agency including contact information, coverage, treatment planned and completed.

_____ _____

Signature of Patient / Parent / Guardian Date