SOUTH TRAIL CROSSING **DENTAL**

We are Dedicated To You and Your Family

#57, 4307-130th Ave SE, Calgary, Alberta T2Z 3V8 T: **403.720.2778** www.southtrailcrossingdental.com

Patient Information:

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name PLEASE PRINT CLEARLY

Title **Mr / Ms / Mrs / etc**	Last Name	First Name	Middle Initial

Preferred Name	Date of Birth **DD / MM / YYYY**	Gender ◯ **Male** ◯ **Female**	Family Status ◯ **Married** ◯ **Single** ◯ **Child** ◯ **Other**

Address	City	Province	Postal Code

Home Phone #	Cell Phone #	Work Phone #	Extension #	Best Time to Call ◯ **Mornings** ◯ **Afternoons** ◯ **Evenings**

Email Address	Previous Visit to our office / Date

Whom may we thank for referring you to our Practice?
◯ **Google** ◯ **Internet** ◯ **Sign out Front** ◯ **Mail out Card** ◯ **Other (name in next section)**

Name of person, office, or other source referring you to our Practice

As a Courtesy to our patients, this office accepts assignment of benefits. If a patient chooses to have dental services rendered through insurance primarily, the patient must leave a valid credit card on file. Any balances not covered through the patient's insurance plan will automatically be put on the patient's credit card on file and a receipt will be emailed.

Dental Insurance Information:

Name of Insured Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Last Name	First Name	Date of Birth **DD / MM / YYYY**

Insurance Plan Name	Group #	ID#

Secondary Insurance Information:

Name of Insured Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Last Name	First Name	Date of Birth **DD / MM / YYYY**

Insurance Plan Name	Group #	ID#

Please Select one of the following Billing Methods ◯ Non-Assignment of Benefits ◯ Assignment of Benefits

Name of Card Holder

Last Name	First Name	Date of Birth **DD / MM / YYYY**

Credit Card #	Expirey Date

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in full at the time services are performed. I understand that the financial obligation for any services rendered / received is my responsibility and not the responsibility of the Dental Practice, or my insurance carrier. I understand that the Dental Practice will make reasonable effort on my behalf to obtain all applicable benefits from my insurance carrier if I have chosen Assignment of benefits, but there is no promise or guarantee of payment / coverage. Any balance due after insurance processing and / or insurance payment received is my responsibility and will be charged directly to the credit card on file. Our office requires a minimum of two business days notice to change or cancel an appointment. Failure to provide this notice may result in a rescheduling fee.

I have read the above conditions of treatment and payment and agree to their content ◯ **Yes**

Signature: ▶ _____

Signature of patient, parent, or guardian (responsible party)

Date	Response Date

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Medical & Dental History Form (a):

Please take a moment to to let us know about your medical and dental history so we can serve you more effectively and in a way that watches out for your overall health and well-being.

FOR OFFICE USE ONLY

☐ *Pre-Medication ☐ *See Patient Notes ☐ Allergy -*See Notes

Patient Name PLEASE PRINT CLEARLY

Full Name	Date

Your Primary Care Physician's name, address, & phone number:

Care Physician's Name	Care Physician's Address	
Care Physician's Phone	What is the date (or approximate date) of your last medical exam?	Aprox. Date

Please mark any of the following to indicate YES in response to the questions:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Are you currently taking any prescription or non-prescription medications?

If marked YES please list / explain the medications you are currently taking below

Are you Allergic to any of the following:

☐ Aspirin	☐ Iodine	☐ Penicillin
☐ Codeine	☐ Latex	☐ Sulfa
☐ Erythromycin	☐ Metal	☐ Local Anesthetic

☐ Other

Please List / Explain any other allergies you have below

Women: are you ☐ Pregnant / Trying to get preagnant? ☐ Nursing? ☐ Taking oral contraceptives?

If pregnant when is the due date?

Please indicate if you have experienced any of the following:

☐ Arthritis	☐ Epilepsy	☐ Hearing Disabled	☐ Jaundice	☐ Pregnancy	☐ Skin Rash
☐ Artificial Joints	☐ Excessive Bleeding	☐ Heart Disease	☐ Kidney Disease	☐ Respiratory Problems	☐ Stroke
☐ Asthma	☐ Excessive Bruising	☐ Heart Murmur	☐ Low Blood Pressure	☐ Radiation Treatment	☐ TMJ
☐ Blood Thinner	☐ Gastro - Intestinal	☐ Hepatitis A	☐ Liver Disease	☐ Rheumatic Fever	☐ Thyroid Disease
☐ Cancer	☐ Glaucoma	☐ Hepatitis B	☐ Mental Disorders	☐ Rheumatism	☐ Tuberculosis
☐ Contraceptive Use	☐ Hay Fever	☐ Hepatitis C	☐ Multiple Sclerosis	☐ Rheumatoid Arthritis	☐ Tumors
☐ Diabetes	☐ High Blood Pressure	☐ High Cholesterol	☐ Nervous Disorders	☐ Sinus Problems	☐ Tonsillitis
☐ Dizziness / Fainting	☐ Hard to Freeze	☐ HIV Positive (AIDS)	☐ Osteoporosis	☐ STD	☐ Ulcers
☐ Emphysema	☐ Head Injury	☐ Hives	☐ Pacemaker	☐ Stomach Problems	☐ Wheelchair

Do you have any other health issues not listed above? Please Explain

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Medical & Dental History Form (b):

Please take a moment to to let us know about your medical and dental history so we can serve you more effectively and in a way that watches out for your overall health and well-being.

Patient Name PLEASE PRINT CLEARLY

Full Name	Date

What is the reason for your dental visit today?

Comments / Notes

When was your last visit to the dentist (if to a different office)? Aprox. Date

Please mark any of the following to indicate YES in response to the questions:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?

How frequently do you brush your teeth?

☐ 3(+) a day	☐ Twice a day	☐ Once a day	☐ Weekly	☐ Seldom

How frequently do you floss your teeth?

☐ 1(+) a day	☐ 2 - 6 weekly	☐ 1 - 6 Monthly	☐ Seldom	☐ Never

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and / or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependant(s) to third-party insurance carriers, payors, and / or healthcare practitioners.

We respect our patients' time and ask the same in return. If you cancel or fail to show for an appointment there may be a fee.

I have read the above authorizations and agree to their content ○ Yes

Signature: ▶ _____

Signature of patient, parent, or guardian (responsible party)

Date	Response Date