OLD STONY DENTAL
Periodontics & Endodontics

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CONFIDENTIAL PATIENT INFORMATION AND HEALTH HISTORY

TODAYS DATE:_____

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____
Sex: ☐M ☐F Date of Birth: _____ Age: ____ Weight: _____ Height: _____ Marital Status: _____
Name of Spouse: _____ Alberta Health Card: _____
Mailing/Home Address: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____ Preferred: ☐Home ☐Cell
Email Address: _____
Personal Physician: _____ Phone: _____
Emergency Contact: _____ Relationship: _____
Phone: _____ Alternate Phone: _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE COMPANY
Employer: _____
Business Address: _____
Phone: _____
Insurance Co.: _____
Policyholder Name: _____
Policyholder DOB: _____
Policy/Group No.: _____
ID Number: _____

SECONDARY DENTAL INSURANCE COMPANY
Employer: _____
Business Address: _____
Phone: _____
Insurance Co.: _____
Policyholder Name: _____
Policyholder DOB: _____
Policy/Group No.: _____
ID Number: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

The following is for: ☐Patients Spouse ☐Person Responsible for Payment

Name: _____ Relationship: _____

Phone: _____ Email: _____

DENTAL INFORMATION

Are you in any pain? ☐ Yes ☐ No How long have you been in pain? _____

Please indicate if you have any of the following problems by checking off the corresponding box:

☐Discomfort, Clicking or Jaw Popping	☐ Red, Bleeding or Swollen Gums	☐Teeth Grinding
☐Locking Jaw	☐ Sensitive Tooth or Gums	☐ Ringing Ears
☐Bad Breath	☐ Blisters/Sores in or Around Mouth	☐ Other

Please explain if Other: _____

_____

Have you ever required pre-medication? ☐ Yes ☐ No

Last Dental Exam: _____ Last Dental Hygiene: _____

How many times a day do you brush: _____ How many times a day do you floss: _____

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MEDICAL HISTORY AND INFORMATION

Are you taking any of the following medications?

☐ Stimulants ☐ Blood Thinners ☐ Nerve Pills ☐ Pain Killers
☐ Muscle Relaxant ☐ Tranquilizers ☐ Insulin ☐ Other

Other Medications/Herbal Supplements/Non-Prescription Drugs: _____

_____

Are you using any form of recreational drugs? ☐ Yes ☐ No
Have you ever gained or lost excessive weight recently? ☐ Yes ☐ No
Have you ever had radiation or x-ray therapy? ☐ Yes ☐ No
Have you ever taken cortisone or steroids? ☐ Yes ☐ No
Do you smoke or chew Tobacco? ☐ Yes ☐ No For how long? _____
Have you ever had a total joint replacement (e.g. hip) ☐ Yes ☐ No When? _____
When was your last full medical exam?_____
Has there been any changes in your general health in the past year? If so, please explain:

_____

_____

FOR WOMEN ONLY:
Are you taking Birth Control Pills or other Contraceptives? ☐ Yes ☐ No
Are you currently Pregnant? ☐ Yes ☐ No If so, how many months? _____
Are you currently breast-feeding? ☐ Yes ☐ No

MEDICAL HISTORY AND INFORMATION CONTINUE...

Have you ever had or have any of the following? Please check those that apply:

☐ AIDS	☐ Allergies	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Aspirin Allergy	☐ Asthma	☐ Back Problems
☐ Barbiturates Allergy	☐ Blood Disease	☐ Cancer	☐ Codeine Allergy
☐ Diabetes	☐ Dizziness	☐ Epilepsy	☐ Excessive Bruising
☐ Fainting	☐ Gastrointestinal	☐ Glaucoma	☐ Growths
☐ Hard to Freeze	☐ Hay Fever	☐ Head Aches	☐ Head Injuries
☐ Heart Disease	☐ Hepatitis	☐ HIV +	☐ HIV -
☐ Hives	☐ Iodine Allergy	☐ Jaundice	☐ Kidney Disease
☐ Latex Allergy	☐ Liver Disease	☐ Local Anesthetic Allergy	☐ Mentally Challenged
☐ Multiple Sclerosis	☐ Nervous Disorders	☐ Pacemaker	☐ Penicillin Allergy
☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Sinus Problems	☐ Skin Rash	☐ Stomach Problems	☐ Stroke
☐ Sulfa Allergy	☐ Thyroid Disease	☐ TMJ	☐ Tuberculosis
☐ Tumors	☐ Ulcers	☐ Venereal Disease	☐ Other

Please explain if Other: _____

Do you have Excessive Bleeding? ☐ Yes ☐ No Do you have a Heart Murmur? ☐ Yes ☐ No
Do you have either: Low Blood Pressure? ☐ Yes ☐ No High Blood Pressure? ☐ Yes ☐ No
Have you ever been put on CPAP Therapy for treatment? ☐ Yes ☐ No

Appointments:
Please help us maintain the operation of our office on sound principle so that we may assure you and other patients of uninterrupted treatment. Your scheduled appointment is reserved exclusively for you. We have a 48 hour cancellation policy in order to provide you with this personalized attention. We understand that circumstances may arise that require an appointment to be rescheduled. We are happy to change your appointment time if a 48 hour notice is given. If sufficient notice is not given, we may require a $100 deposit to secure your next appointment. We ask that you make every effort to keep your reserved time.

Payment of Fees:
This office is a Non-Assignment Office. You will be responsible for the full amount. Your payment is due and payable on the day of your appointment. We do accept cash (exact amount), credit (VISA or Mastercard), or debit.

General Release:
I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I also authorize the communication of information related to the coverage of serviced described in this form to the named doctor.

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

I have read the above conditions of treatment and payment and agree to their content.

Signature: _____ Date: _____

Signature of patient, parent or guardian