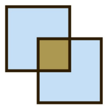

TREY PETTY ORAL HEALTH
Compassionate Care

Patient Information

(please print – If you need help with this form, please ask our staff)

Full Legal Name:		Birthdate: (yyyy/mon/dd):	
Patient Lives At:		Email:	
City:	Province:	Postal Code:	
Home #:	Work #:		Cell #:
Alberta Healthcare #:	Medical Decisions Made By: ❑ Self ❑ Guardian / POA ❑ Trustee		**AISH/ALBERTA WORKS#:**
Guardian / POA name and phone #:			Email:
Trustee Name and phone #:			Email:
Caregiver Name and phone #:			Email:
Billing Address (if different):			
City:	Province:	Postal Code:	
Insurance Co: Self	**Policy/Plan #:**		**ID/Certificate #:**
Insurance Co: Spouse/Partner **Name:** **Birthdate:**	**Policy/Plan #:**		**ID/Certificate #:**
Referred by Dentist / Physician / Other (please circle) **Name:**	**Primary Care Physician:** **Other physicians:**		

Please circle the MOST CONVENIENT way to contact you (confirm appointments, etc.):

EMAIL / TEXT / CELL / HOME PHONE / WORK PHONE

THE LEGAL BITS: (this is available in a larger type font, if requested)

CONSENT AND USE OF PERSONAL INFORMATION:
We are committed to protecting the privacy of our patient's personal information and will utilize any information collected in a responsible and professional manner, according to Alberta Privacy laws. If you choose to be contacted by email/Internet, please be aware there are inherent limits to protecting your privacy. Please initial that you have read and accept this: _________ *(please initial)*

PAYMENT POLICY:
We are pleased to provide the latest technology for processing your dental claims. We are able to submit claims electronically while you wait, and often receive a response immediately to verify the submission. We normally do not direct bill your insurance company (except AISH, Alberta Works and Alberta Seniors Benefit clients) and payment is expected at the end of your appointment. We are happy to provide treatment estimates or insurance pre-determinations at your request.

CANCELLATION POLICY:
Your time is important to us and we are pleased to reserve scheduled time for you.
Missed or cancelled appointments increase the wait time for all of our patients. We ask that you provide at least 2 business days' notice to change or cancel an appointment. A fee of $100 per hour may be charged for missed or short notice cancelled appointments which will be billed to you directly, as insurance companies will not cover this fee.

X ____

Patient / Guardian / POA signature **Date (yyyy/mon/dd)**

(Please turn over)

Medical History

Chief Complaint (Why are you here?): ______________________

Yes No

1) ❑ ❑ Are you feeling well today? What is your approximate weight? ____________

2) ❑ ❑ Have you been a patient in a hospital during the past two years?

3) ❑ ❑ Are you allergic (i.e. itching, rash, swelling) to penicillin, aspirin / ASA, codeine or any drugs or medications?
If so, what? ______________________

4) ❑ ❑ Have you ever had any excessive bleeding requiring special treatment?

5) Check ☑ any of the following, which you have now at present, or have ever, had in the past:

- ❑ Heart Failure or Disease
- ❑ Heart Disease or Attack
- ❑ Angina Pectoris
- ❑ High Blood Pressure
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Congenital Heart Defects
- ❑ Artificial Heart Valve
- ❑ Heart Pacemaker
- ❑ Heart Surgery
- ❑ Artificial Joint
- ❑ Anemia
- ❑ Stroke / Brain Injury
- ❑ Kidney Trouble
- ❑ Hemo- or Parenteral Dialysis
- ❑ Ulcers
- ❑ Headaches / Migraines
- ❑ Mentally Challenged
- ❑ Dementia
- ❑ Wheelchair User
- ❑ Emphysema / COPD
- ❑ Lung or Breathing Problems
- ❑ Tobacco Use
- ❑ Tuberculosis (TB)
- ❑ Asthma
- ❑ Organ Transplant
- ❑ Sinus Problems
- ❑ Allergies or Hives
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ Cancer, Leukemia, Myeloma
- ❑ Radiation or Cobalt Treatment
- ❑ Chemotherapy
- ❑ Rheumatoid or Osteo – Arthritis
- ❑ Rheumatism
- ❑ Cortisone / Steroid Medicine
- ❑ Glaucoma
- ❑ Pain in Jaw Joints
- ❑ HIV
- ❑ Hepatitis A / B / C
- ❑ Liver Disease
- ❑ Yellow Jaundice
- ❑ Blood Transfusion
- ❑ Drug Addiction
- ❑ Alcohol Abuse / Alcoholic
- ❑ Hemophilia
- ❑ Venereal Disease (syphilis, gonorrhoea)
- ❑ Cold Sores
- ❑ Epilepsy or Seizures
- ❑ Fainting or Dizzy Spells
- ❑ Nervousness
- ❑ Psychiatric Treatment
- ❑ Sickle Cell Trait / Disease
- ❑ Bruise Easily
- ❑ Snoring / Sleep Apnea
- ❑ Injury to Face or Mouth

Yes No

6) ❑ ❑ Do you have any disease(s), conditions(s) or problem(s) not already listed?
If so, what? ______________________

7) ❑ ❑ Have you **ever** taken bisphosphonate medications, including: Actonel (risedronate), Boniva (ibandronate), Fosamax (alendronate), or (Aredia) pamidronate?

8) ❑ ❑ **Women:** Are you currently pregnant or breast-feeding?

9) Please list all your current medications:
(or provide a list, if available)______________________

____

Dental History

Yes No

1) ❑ ❑ Do you have tooth, gum or head and neck pain or discomfort?

2) ❑ ❑ Do you feel very nervous about dental treatment?

3) ❑ ❑ Do you notice popping, clicking or soreness of the jaw?

4) ❑ ❑ Are you involved in any contact sports?
(i.e. hockey, football, boxing, basketball, etc.)

5) ❑ ❑ Do you have a dry mouth?

6) ❑ ❑ Do you have problems with dental freezing/numbing?

7) ❑ ❑ Are you happy with the appearance of your teeth/smile?
If not, please specify:

8) **a)** When was your last dental visit?____________

b) Were dental x-rays taken? Yes / No

c) When was your last dental cleaning?____________

d) Who was your last dentist?____________

9) **a)** If you wear complete or partial dentures? Yes / No

b) How many years have you worn dentures?________

c) How old are your present dentures?____________

____