Redcliff Family Dental Centre

Today's Date:_____

Name:_____

Address:_____ Postal Code:_____

Home Phone #:_____ Employer:_____

Cell Phone #:_____ Occupation:_____

Date of Birth:_____Gender: M F Work Phone#:_____

Email:_____ Marital Status:_____

Emergency Contact:_____ Phone#:_____

Physician: _____ HealthCare #: _____

How did you hear about our office?_____

Medical History

Do you have any allergies that you are aware of? If yes, please list: _____

Do you have a Latex allergy? O Yes O No

Have you ever been hospitalized? O Yes O No

Women: Are you pregnant? O Yes O No

Are you taking any medications or supplements? Yes No If yes, please list:

_____

_____

_____

Please circle any of the following conditions that apply to you, past or present

Anemia
Anorexia or Bulimia
Arthritis
Artificial Joints
Artificial Heart Valves
Asthma/Breathing Problems
Blood Disorders/Issues
Cancer
Clotting/Bleeding Problems
Cold Sores
Depression
Diabetes
Drug use/substance abuse
Epilepsy
Fainting
Fibromyalgia
Gastrointestinal Disease
G.E.R.D
Growth or Tumor
Heart Attack/Chest Pain/Angina
Heart Disease
Heart Murmur
Hearing Impairment
Hepatitis A B C
Hemophilia
HIV/AIDS
High or Low Blood Pressure
Jaundice
Kidney Disease/Dialysis
Leukemia
Liver Problems
Mental/Nervous Disorders
Migraines/Headaches
Mitral Valve Prolapse
Organ Transplant
Osteoporosis
Pacemaker/Defibrillator
Rheumatic Fever
Sinus Problems
Sleep Apnea
Snoring
Stroke
Surgery
Thyroid Problems
Tuberculosis
Ulcers

Is there anything else you would like us to know about your health?

_____

_____

Patient's Signature: _____ Date: _____

Redcliff Family Dental Centre

Today's Date:_____

Dental History

Purpose of your visit today?_____

Have you ever experienced any of the following?

Does your jaw click or hurt?	O Yes	Do you smoke or use chewing tobacco?	O Yes
Do you grind your teeth?	O Yes	Have you ever had issues w/dental freezing?	O Yes
Do you wear a night guard?	O Yes	Do you experience hot/cold sensitivity?	O Yes
Have you ever had your bite adjusted?	O Yes	Does floss ever tear between your teeth?	O Yes
Do your gums bleed when you brush?	O Yes	Does food get stuck between your teeth?	O Yes
Do you bite your cheeks or lips often?	O Yes	Do your teeth hurt when you bite hard?	O Yes
Does your mouth often seem dry?	O Yes	Have you ever had braces?	O Yes
Do you ever have bad breath?	O Yes	Have you been told you have gum disease?	O Yes

Are any of your teeth sore or aching? Yes / No If yes, which tooth or area? _____
When was your last visit to the dentist? _____Last cleaning & x-rays? _____
Have you ever experienced problems with dental treatment? _____

What is your dental comfort level on a scale from 1 to 10? ☹ 1 2 3 4 5 6 7 8 9 10 ☺
How often do you brush your teeth? _____ How many times per week do you floss? _____

Rate your smile: ☹ 1 2 3 4 5 6 7 8 9 10 ☺
What would you like to change or improve in your teeth or smile?_____
Is there anything you would like to make us aware of that has not been covered on this form?
_____

Permission to Treat, Release of Information & Privacy

I hereby authorize the designated dental team to take x-rays, impressions, photographs, and other diagnostic aids needed to make a thorough diagnosis. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed by me and to employ such assistance as required to provide care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. We are committed to protecting the privacy of our patients' personal information and utilizing all personal information in a responsible and professional manner. We collect, use and disclose personal information when permitted or required by law. We disclose this to third party health benefit providers and insurance companies where the patient has submitted a claim or has asked us to submit a claim on the patient's behalf. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents. We collect health history and dental history information from our patients. This is used for diagnosing dental conditions and providing treatment. Patient's Medical Information is disclosed to:

- 3rd party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment for dental treatment or has asked us to submit a claim on the patient's behalf.
- To other dentists/ specialists, when seeking a 2nd opinion with patient consent to obtain a 2nd opinion.
- To other dentists/ specialists, if the patient has been referred to us by them for treatment with consent.
- To other dentists/ specialists where they have asked us, with patient consent, to provide a 2nd opinion.
- To other health care professionals/ 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 granted access as part of the due diligence process to patient information in order to verify information important to a potential office sale, we will take steps to ensure that the prospective purchaser safeguards all personal information. Dentists are regulated by the ADA+C 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 disclosure of my personal information as set out above.

Patient's Signature: _____ Date: _____