Calgary's Dental Care

CALGARY DENTAL CENTERS

17th Avenue Dental Center

Patient information

Full Legal Name: _____

First Middle Last

Date of Birth: YYYY / MM/ DD

Home Address/ Postal Code: _____

Telephone: Cell _____Home _____Work _____

Email: _____ Alberta Health Care Number: _____

Emergency Contact Name: _____ Phone: _____

If Patient Is Under 18:

Legal Guardian Name: _____ Phone: _____

Who May We Thank For Your Referral? _____

Medical Information

Your Doctor's Name: _____ Phone: _____

Date and Reason for Last Visit: _____

_____

Medications: _____

_____

Allergies: _____

Surgeries: _____

Hospitalizations: _____

(Continues in next page)

(Continues from previous page)

Chest pain:	◯ Yes	◯ No
Bleeding disorders:	◯ Yes	◯ No
Do you smoke? How much?	◯ Yes	◯ No
Do you drink alcohol? How much?	◯ Yes	◯ No
New cough or shortness of breath	◯ Yes	◯ No
New fever or chills in the last 24 hours	◯ Yes	◯ No
New onset of diarrhea	◯ Yes	◯ No
New rash, lesion or break in the skin	◯ Yes	◯ No
Recent exposure to communicable infectious disease, e.g. measles, chicken pox, tuberculosis.	◯ Yes	◯ No
History of artificial joints or heart valves or transplants or implants	◯ Yes	◯ No

History of antibiotic therapy: _____

_____

Family history of diseases: _____

_____

Immunization History: _____

_____

Immunosuppressive medications: _____

_____

Is there anything else I should know about your medical history or general medical health?

_____

_____

Dental Information

What is your immediate dental concern?

_____

What dental care would you like today?

_____

When was your last dental visit? What treatment was done?

_____

Why did you leave your last dentist?

_____

Tell me about your past experiences with dental care.

_____

How important is your smile to you?

_____

Can you eat and drink comfortably?

_____

Any pain, infection or bleeding with your gums, teeth, jaw joints?

_____

Have you felt that your sense of taste or digestion has worsened? Yes ◯ No ◯

Any bad breath? Bad taste? Yes ◯ No ◯

Do you snore? Yes ◯ No ◯

Uncomfortable dentures? Yes ◯ No ◯

Any suggestion to improve the look and feel of your smile?

_____

_____

Any concerns regarding your future dental care? Pain? Time? Cost? Fears?

_____

Payment policy, cash-debit-credit

Our office policy is to ask patients to cover the cost of dental services at the time they are provided. If you are deeply concerned that the fee will pose financial stress on you, please inform us. Ask us about payment plans O.A.C.

Outstanding accounts over 30 days will accrue and interest of 2 % per month.

As a service and courtesy to our patients we will submit your insurance forms. If for any reason your dental insurance does not pay for your dental care you are responsible for the fees. It is your responsibility to know your dental insurance coverage and provide us with correct information. Get your tax deductible receipt!

Consent treatment and patient rights.

I completely understand and agree that I have accurately and truthfully provided all the above information. I also understand that I am responsible for the costs associated with my or my dependants' dental care. I understand I have the right to ask any questions about my dental treatment. I understand I have the right to say no to any proposed dental treatment. I will be given all the advantages, disadvantages, risks, alternatives, benefits, and fees if requested.

_____

Patient signature (legal guardian or parent if under 18)

_____

Staff witness signature

_____

Dentist signature

_____

Date.

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Policy regarding missed appointments

Dear patient:

Please understand that your dental appointment is reserved for you. When you miss your appointments, it affects many people. If two business days' notice is not given, a fee of $95.00 may be assessed.

Thank you.

_____

Patient signature

For assignment (**billing insurance**) we require:

Copy of driver's license ☐

Credit card number ☐

Benefits

I authorize release to my dental benefits plan administrator and CDA of the information contained in claims submitted electronically.

This authorization shall continue in effect until the undersigned revoked the same.

_____ _____

Signature of patient, parent or guardian. **Date**

I hereby assign my benefits, payable from claims submitted electronically, to Dr. _____ and I authorize payment directly to him/her.

This authorization shall continue in effect until the undersigned revoked the same.

_____ _____

Signature of patient, parent or guardian. **Date**