Gasoline Alley DENTAL

New Patient Information and Dental History Form

Patient Information

Preferred method of contact: Text Email Phone

Patient Name: _____ DOB: _____ Gender: _____
Last First Initial (dd/mm/yyyy)

Address: _____
Street City Province Postal Code

Phone: _____ Referred by: _____
Cell Home Work

Email: _____ Family Doctor: _____
Name Phone Number

Emergency Contact: _____
Name Phone Number

Insurance Information (if no insurance, please leave blank)

Primary Dental Insurance

Name of Insured: _____ DOB: _____
Last First (dd/mm/yyyy)

Insurance Company: _____
Group/Plan/Policy #: _____ Certificate/ID #: _____
Insured's Employer Name: _____

Secondary Dental Insurance

Name of Insured: _____ DOB: _____
Last First (dd/mm/yyyy)

Insurance Company: _____
Group/Plan/Policy #: _____ Certificate/ID #: _____
Insured's Employer Name: _____

Dental History:

Do you need to take antibiotics prior to dental appointments? (If yes, please list) _____

Have you ever had complications following dental treatment? _____
When was your last dental visit? _____
Do your gums bleed when you brush or floss? _____
Do your teeth experience sensitivity to cold or hot temperatures or sweets? _____
Are any of your teeth currently causing you pain? _____
Do you grind your teeth (either consciously or during sleep)? _____
Have you ever had an allergic reaction to local anesthetic? _____
Are any of your teeth loose or are you concerned about any teeth loosening? _____
Do you currently have dental implants, dentures, or partials? _____
Have you ever had any surgery in your mouth? _____

106, 179C Leva Ave
Red Deer County, AB T4E 0A5

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Tel: 403-343-8622
Fax: 403-341-6464

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Do you use tobacco? _____
Do your jaws crack, pop, or grind when you open widely? _____

Cancellation/Missed Appointment Policy

We understand that emergencies come up and appointments sometimes need to be cancelled or changed. As a courtesy to all of our patients and staff, we ask that you let us know at least 24 hours in advance if you need to cancel or change your appointment. Since we have reserved that specific appointment time just for you, we ask that you show us the same care and consideration by giving us at least 24 hours' notice. **If you have had 3 missed or cancelled appointments without giving 24 hours' notice, then you may be charged a cancellation/missed appointment fee as determined by the Alberta Dental Fee guide.**

Consent for Services

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

I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and that I may be billed for this remaining balance.

I understand that any preauthorizations for treatment sent to my insurance carrier on my behalf are just estimates and do not guarantee the exact amount that may be billed and/or covered by my insurance plan.

I understand that any treatment plans given to me are considered an estimate and that cost for actual treatment provided may change as adaptations to treatment plans can and do occur frequently in the dental field.

I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any). This consent shall be considered in effect until rescinded or revoked.

_____ _____
Patient Signature (Parent/Guardian Signature) Date

_____
Patient Name (Printed)

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Medical History Form

Patient Name: _____ DOB: _____ Gender: _____
Last First Initial (dd/mm/yyyy)

Medical History:

Are you currently taking any prescription or non-prescription medications? (If yes, please list)_____

_____

Do you have any known **drug** allergies? (If yes, please list) _____

Do you have any **other** allergies? (If yes, please list) _____

Do you have sensitivity or allergy to latex? _____

Have you been hospitalized within the last 4 years due to a surgery or illness? _____

Are you currently under the care of a physician due to a specific condition? _____

Please indicate with a checkmark if you have had any of the following (**circle the condition that applies**):

Anemia ____	Emphysema ____	Hyper/hypoglycemia ____	Rheumatic/Scarlet Fever ____
Arthritis ____	Epilepsy ____	Hyper/hypothyroidism ____	Sickle Cell Anemia ____
Asthma ____	Hives ____	Kidney Disease ____	Sinus Problems ____
Blood Disorder ____	Excessive Bleeding ____	Jaundice ____	STD/STI ____
Bronchitis/COPD ____	Excessive Bruising ____	Joint Replacement ____	Stomach Problems ____
Cancer ____	Glaucoma ____	Liver Disease ____	Stroke ____
Celiac Disease ____	Head/neck Injury____	Mental Illness ____	Substance Abuse ____
Chron's/Colitis ____	Hearing Impaired____	Mitral Valve Prolapse ____	Tuberculosis____
Circulation problems ____	Heart Attack ____	Multiple Sclerosis ____	Ulcers ____
Cold Sores (Herpes) ____	Heart Disease ____	Organ Transplant ____	Other_____
Contraceptive use ____	Heart Murmur ____	Pacemaker ____	_____
Cortisone/Steroid use ____	Hepatitis A/B/C ____	Pregnancy (currently) ____	_____
Diabetes type 1/2 ____	High/Low BP ____	Pre-Medication ____	_____
Dizziness/Fainting ____	HIV+ ____	Radiation/Chemotherapy ____	_____
Eating Disorder ____	Hodgkins Disease ____	Respiratory Problems ____	_____

_____ _____
Patient Signature (Parent/Guardian Signature) Date

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