SUMMERSIDE DENTAL

Adult Health/Dental History Form

Patient's Name | Mr./Mrs./Miss/Ms/Dr LAST FIRST INITIAL		Date of Birth DD/MM/YYYY
Address HOME CITY PROV PC		
Phone HOME CELL PHONE WORK PHONE		Sex M ❒ F ❒
Email ❒ I consent to e-mail correspondence		Occupation
Patient's Parents/Guardian?or Spouse:		
Spouse's Date of Birth	Spouse's Phone Number	Alberta Personal Health Number

In case of emergency, we should notify

Name	Relationship
Residence Phone	Other Phone
Name of family doctor	Phone ❒ I do not have a family doctor
Name of insuring company, if applicable	

How did you hear about our office? Check all that apply. MAILOUT ❒ LOCATION ❒ WEBSITE ❒ MAGAZINE AD ❒ SOCIAL MEDIA ❒
DIGITAL BILLBOARD ❒ REFERRAL ❒ (By whom) _____ OTHER ❒ _____

All professional services performed are the PERSONAL RESPONSIBILITY OF THE PATIENT and payment is expected when the treatment is rendered. Claims are submitted electronically to assist in collecting the reimbursement of your benefits. Direct billing to an insurance company may be allowed under special circumstances with a credit card number held for any differences. Our treatment plans are not based primarily on what is covered by insurance, but on individual patient needs and preferences.

APPOINTMENTS:
Appointment times are reserved for you. If unable to keep an appointment, please give us at least 24 hours notice to make alternate scheduling arrangements, or a cancellation fee may be charged.

INFORMED CONSENT
PERMIT FOR DENTAL PROCEDURES:
This is to certify that I, the undersigned, will consent to the performing of the dental and surgical procedures agreed to be necessary or advisable, when I have been informed of my options and understand the risks and benefits to my satisfaction. I acknowledge that no guarantee has been provided to me as to the results of treatment, and I assume the risks inherit in dental procedures.

PRIVACY ACT AND ELECTRONIC SUBMISSION:
I understand that the required standards of personal information confidentiality are being met in accordance with the Health Professionals Act and the Alberta Personal Information Protection Act. I hereby authorize the release of information contained in claims to be submitted electronically or by mail to my insurance company.

❒ I explicitly consent to receiving emails and text messages from Summerside Dental.
❒ I have read and understand the above conditions and content.
❒ Adult Waiver/Media Consent Form

I hereby authorize any images or video footage taken of myself, in whole or in part, individually or in conjunction with other images and video footage, to be displayed on the Summerside Dental Website and other official channels, and to be used for media purposes including promotional presentations and marketing campaigns. I also authorize any media material created by myself within Summerside Dental. I waive rights to privacy and compensation, which I may have in connection with such use of my name and likeness, including rights to be written copy that may be created in connection with video production, editing and promotion therewith.

NAME OF PATIENT: _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN: _____

DATE: _____

SUMMERSIDE MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. We will review the questions and explain any that you do not understand.

1. Have you ever required extensive medical care or been HOSPITALIZED for any illness or operation? _____
2. Are you being treated for any medical condition at the present?
3. When was your last medical checkup?
4. What is your BLOOD PRESSURE? BASELINE:
5. Have there been any significant changes in your GENERAL HEALTH or in your WEIGHT in the past year?

   Height: Current Weight: BMI: Neck Circumference:
6. Are you presently taking any MEDICATIONS, non-prescription drugs or herbal supplements of any kind?

   Please list all.
7. Do you have any ALLERGIES?

   a) Medications allergy:

   b) Latex / Rubber products allergy:

   c) Other eg. Hayfever, foods:
8. Have you ever had a peculiar or adverse reaction to any medication or injection?
9. Do you have or have you ever had ASTHMA?
10. Do you have or ever had any HEART or BLOOD PRESSURE problems?
11. Have you ever been diagnosed with sleep apnea of sleep disorder breathing?
12. Have you ever had a HEART MURMUR, mitral valve prolapse or rheumatic fever?
13. Do you have a PROSTHETIC or artificial joint, organ transplant or medical implant?
14. Have you ever been advised by your doctor to take ANTIBIOTICS before dental treatment?
15. Do you have any conditions or therapies that could affect your IMMUNE SYSTEM eg. Leukemia, Steroid Therapy, AIDS, HIV infection, Radiotherapy, Chemotherapy?

16. Have you ever had Hepatitis A, B, C, Jaundice or LIVER Disease?

17. Do you have or have you ever had a BLEEDING disorder, anemia or a clotting problem?

18. Do you BRUISE or bleed easily?

19. Have you ever FAINTED?

20. Do you have frequent or severe HEADACHES?

21. Do you have chronic SINUS problems?

22. Do you have or have you ever had any of the following:

❒ Chest Pain, Angina	❒ Prosthetic Heart Valve	❒ Tuberculosis	❒ Seizures
❒ Heart Attack	❒ Venereal Disease/STD	❒ Steroid Therapy	❒ Arthritis
❒ Stroke	❒ Mental/Nerve Disorder	❒ Diabetes	❒ Epilepsy
❒ Thyroid Disease	❒ Drug/Alcohol Dependency	❒ Stomach Ulcers	❒ Cancer
❒ Kidney Disease	❒ Pacemaker	❒ HIV or AIDS	❒ Fainting
❒ Shortness of Breath	❒ Lung Disease	❒ Diet Pill Therapy	❒ Contact Lenses
❒ Multiple Sclerosis	❒ Migraines	❒ Numbness in Hands	❒ Sleep Apnea

23. Are there any conditions or disease not mentioned above that you have had?

24. Are there any disease or medical problems that run in your family?

25. Do you presently, or have you ever SMOKED or chewed tobacco products? How may cigarettes/day for how many years? Have you ever smoked? If Yes How many per day? How many years?

26. Do you have risk factors for oral cancer such as ALCOHOL use or mouth sores/warts?

27. Have you travelled to another country in the past 3 months?

28. For WOMEN only: Are you pregnant, or think you might be, or nursing a baby? If pregnant, when is the expected delivery date?

To the best of my knowledge, the above information is correct and complete:

PATIENT/PARENT/GUARDIAN SIGNATURE: DATE:

SUMMERSIDE DENTAL HISTORY FORM

When was your last dental visit? _____ Treatment done? _____

When was your last Panoramic x-ray taken? _____

Please rate your current dental health. ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Is there a dental problem that you would like to take care of as soon as possible? ❒ Yes - please indicate ❒ No

_____

Have you ever had a raised bump or sore spots in your mouth? ❒ Yes ❒ No

If yes, then how long has it been present? _____ Tori Mand Max

Would you like a VELscope oral cancer screening test? ❒ Yes ❒ No

How is your sugar intake? ❒ High ❒ Medium ❒ Light

Have you been given oral hygiene instruction in:

❒ Remineralizing Agents ❒ Spin/Power Brushing ❒ Flossing ❒ Advised Mouthrinses

Do your gums bleed when: ❒ Brushing ❒ Flossing ❒ Eating ❒ Never

Do you breathe through your mouth more than your nose? ❒ Yes ❒ No

Do you snore? ❒ Yes ❒ No

Do your teeth experience sensitivity to hot or cold temperatures? ❒ Yes ❒ No

Does food tend to get caught between your teeth? ❒ Yes ❒ No

Do you have any loose teeth? ❒ Yes ❒ No

Do you grind or clench your teeth? ❒ Yes ❒ No

Does your jaw crack, pop or grate when opening or closing? ❒ Yes ❒ No

Do you have any difficulty opening or closing your jaw? ❒ Yes ❒ No

Are your wisdom teeth still present? ❒ Yes ❒ No ❒ Not Sure

Are you tongue-tied? ❒ Yes ❒ No

Do you gag easily? ❒ Yes ❒ No

Would you like to have your teeth whitened? ❒ Yes ❒ No

Are your front teeth aligned ideally to the way you would like? ❒ Yes ❒ No

Overall, are you happy with your smile? ❒ Yes ❒ No

If there were new products available to dramatically freshen your breath would you be interested? ❒ Yes ❒ No

If you could change your smile, what would you change? ❒ Yes ❒ No

Circle the priority that you value most about your teeth: Aesthetics □ Function □ Comfort or Longevity □

Comment: _____

_____

Have you ever had any of the following? (Please circle)

Braces □• Bite Adjustment □• Nightguard or Other Appliances □• Injury to Teeth or Jaws □• Crowns or Bridges □

Dental Implants □• Gum Surgery □• Wisdom Teeth Removed □• Oral Surgery □• Root Canal Therapy □• Dentures □• Sports Guard □

Do you have any concerns regarding your dental visit with us? (Please check)

Fear □• Pain □• Time □• Money □• Embarrassment □• Other: _____