WELCOME TO OUR DENTAL OFFICE

Date_____

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our administrative staff is available to assist you with the completion of this form. PLEASE PRINT.

REGISTRATION INFORMATION

Name:_____Dr. □ Mr. □ Mrs. □ Ms. □ Miss. □
(last) (first)
Address:_____
(street) (apt.#) (city) (province) (postal code)
Home Phone: (____)_____ Bus. Phone: (____)_____Ext._____
Cell Phone: (____)_____
Email:_____
Date of Birth: D_____M_____Y_____ Age:_____ Sex:_____
Marital Status:_____ Name of Spouse:_____
Are other family member's patients at our office? Yes □ Names:_____
How did you hear about our office? Friend/Relative □ Name: _____
Advertising □ Internet □ Other □_____

INSURANCE INFORMATION

Please complete all information if applicable:
Insurance Company Name:_____
Policy Holder: Self: □ Spouse: □ _____
Group/Policy#:_____
Member ID/ Certificate #:_____

Please Complete if you have Secondary Insurance:
Insurance Company Name:_____
Policy Holder: Self: □ Spouse: □ _____
Group/Policy#:_____
Member ID/ Certificate #:_____

□ I authorize Dr. Nenad Vrbancic to electronically submit my dental insurance on my behalf.

229, 200 Barclay Parade S.W., Calgary, Alberta T2P 4R5
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www.eauclairedental.ca

EAU CLAIRE MARKET DENTAL CENTRE
DR. NENAD VRBANCIC

MEDICAL HISTORY

Please check YES or NO to each question

	YES	NO
1) Are you being treated for any medical condition at present?	☐	☐
Medical Dr's Name_____ Telephone Number_____		
2) Have you been hospitalized in the past two years?	☐	☐
3) Has there been any recent change in your general health?	☐	☐
4) When was your last medical checkup? _____		
5) Have you recently taken or currently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Please list: 1._____ 2._____		
6) Have you ever reacted to any of the following? **(please circle)**		
Aspirin Codeine Dalacin Keflex		
Narcotics Penicillin Sulfa Valium Local Anesthetic (freezing)		
Other: _____		
7) Do you have ANY other allergic conditions?	☐	☐
-metal allergy	☐	☐
-latex allergy	☐	☐
-other_____	☐	☐
8) Have you ever been advised against any specific type of medication?	☐	☐
Please list: _____		
9) Have you been advised by a Medical Doctor or Dentist to take antibiotics prior to dental treatment?	☐	☐
10) Do you have a bleeding problem or disorder?	☐	☐
11) Do you smoke any form of tobacco? _____	☐	☐
12) Have you tested HIV positive or come in contact with the AIDS virus?	☐	☐
13) **WOMEN ONLY:** Are you pregnant or suspect you may be?	☐	☐

INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY OR EVER HAD

	YES	NO		YES	NO		YES	NO
AIDS	☐	☐	Glandular disorders	☐	☐	Lung disease	☐	☐
Anemia	☐	☐	Fainting or dizzy spells	☐	☐	Malignant Hyperthermia	☐	☐
Angina pectoris	☐	☐	Hepatitis A, B, C (circle)	☐	☐	Organ transplant	☐	☐
Arthritis	☐	☐	Head/neck injuries	☐	☐	Psychiatric treatment	☐	☐
Artificial heart valve	☐	☐	Heart disease/attack	☐	☐	Radiation treatment	☐	☐
Artificial joints	☐	☐	Heart murmur	☐	☐	Rheumatic/Scarlet fever	☐	☐
Asthma	☐	☐	Heart pacemaker	☐	☐	Sickle cell disease	☐	☐
Blood disorders	☐	☐	Heart rhythm disorder	☐	☐	Sinus trouble	☐	☐
Bronchitis	☐	☐	Heart surgery	☐	☐	Stomach/intestinal problems	☐	☐
Cancer	☐	☐	HIV	☐	☐	Stroke	☐	☐
Circulation problems	☐	☐	High blood pressure	☐	☐	Thyroid disease	☐	☐
Congenital heart lesions	☐	☐	Low blood pressure	☐	☐	Tuberculosis	☐	☐
Cortisone/steroids	☐	☐	Hodgkins disease	☐	☐	Ulcers	☐	☐
Diabetes	☐	☐	Hyper (Hypo) Glycemia	☐	☐	Liver disease	☐	☐
Emphysema	☐	☐	Jaundice	☐	☐	Other_____		
Epilepsy or seizures	☐	☐	Kidney disease	☐	☐			

Do you wish to speak to the Doctor privately about any problem or medical condition? ☐ ☐

_____ PRINTED NAME

_____ SIGNATURE

_____ DATE

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DENTAL HISTORY

Please check YES or NO to each question

Reason for today's visit? Examination □ Other □_____
Date of your last dental visit:_____dental cleaning:_____
May we call a previous dentist for current dental x-rays? Yes □* No □
*If YES, please provide the following:
Previous dentist:_____
Address:_____
Telephone Number: ( )_____

	YES	NO
1) Is there a dental problem you would like treated immediately? Please describe:_____	□	□
2) Have you seen a dentist regularly?	□	□
3) Are there any growths or sore spots in your mouth?	□	□
4) Do your gums bleed when brushing or eating?	□	□
5) Do you suffer from mouth pain or swelling?	□	□
6) Have you noticed any loose teeth or have any of your teeth shifted?	□	□
7) Are any of your teeth sensitive to heat, cold, sweets or pressure?(circle)	□	□
8) Does food catch between any of your teeth?	□	□
9) Are you aware of clenching or grinding your teeth?	□	□
10) Do you suffer from frequent headaches?	□	□
11) Have you ever experienced the following jaw problems?		
-Popping/clicking in your jaw joints?	□	□
-Pain in your jaw joints around your ear or side of your face?	□	□
-Difficulty in opening or closing your jaw?	□	□
-Painful or sore jaw muscles?	□	□
-Pain or difficulty while chewing?	□	□
12) Are you missing any teeth?	□	□
-Have you had the spaces replaced?	□	□
-Would you like them replaced?	□	□
13) Are you unhappy with the appearance of your teeth?	□	□
-What would you like to see changed?_____		
14) Are you interested in any of the following?		
□ Teeth whitening or bleaching		
□ Orthodontic treatment		
□ White fillings		
□ Other_____		
15) Are you feeling anxious about today's dental visit?	□	□

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Office Policy

APPOINTMENTS

Please help us to maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore at least 48 HOURS NOTICE **MUST** be given if cancellation is absolutely necessary. Please be aware, if the 48 hours is not provided that our office reserves the right to charge your account $100.00 for a missed or short notice cancellation appointment.

PAYMENT OF FEES

1) You are responsible for full payment at the time of your visit.
2) This office is willing to electronically submit your claim to your insurance on your behalf to ensure a quick reimbursement from your insurance company.
3) You are responsible for providing the necessary information in order for us to electronically submit to your insurance company.
4) In the instance that the insurance claim does not electronically submit we will mail your claim for you.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I also authorize the communication of information related to the coverage of services described in this form to the named doctor.

CONSENT

I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor and clinical staff to make a thorough diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and consent to the use of local anaesthetic agents. I understand the above statements regarding the payment of fees and accept the responsibility for payment for Dental Services provided for myself or my dependents, due and payable when services are rendered.

I, the undersigned give permission for the doctor of this office and his clinical staff to carry out the necessary treatment needed for dental services.

Patient Signature:_____Date:_____

Parent or Responsible Party:_____
Relationship to Patient:_____

Witness:_____Date:_____

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