



HILLHURST DENTAL CENTRE

New Patient Information

Name _____
Birthdate ____/____/_____
Address _____
City _____ Prov. ____ Postal _____
Home Phone _____
Cell Phone _____
Email _____

How did you hear about our office (Referral,
Google, Street Sign)?

Emergency Contact

Phone _____
Name of previous dental office

When was the last exam and hygiene visit?

Responsible Party/Guardian

Name of person responsible for account

Relationship to patient _____
Cell Phone _____

Dental History

1. Do your gums bleed during brushing/ flossing? Y/N
2. Are your teeth sensitive to hot/ cold/ sweet/ sour? Y/N
3. Do you have any pain in your teeth? Y/N
4. Do you have any sores or lumps in or near your mouth? Y/N
5. Have you had any head, neck, or jaw injuries? Y/N
6. Do you grind or clench your teeth? Y/N
7. Do you experience any Jaw Clicking, Pain, Difficulty Chewing, Migraines or Headaches? Y/N
8. Do you snore or have sleep apnea? Y/N
9. Are you interested in improving your smile aesthetics? Y/N
 - a. Are you open to orthodontics to correct your bite/smile? Y/N
 - b. Are you open to gum surgery/procedures to correct your smile? Y/N
10. Have you had orthodontic treatment? Y/N
11. Do you wear dentures or partials? If yes, for how long? Y/N
12. Have you ever used Tobacco Products? Y/N

Insurance Information

Primary

Name of Insured

Birth Date(Mo/D/Yr) ____/____/_____
Relationship to Patient

Name of Insurance Company

Group # _____ Division # _____
ID # _____

Secondary

Name of Insured

Birthdate ____/____/_____
Relationship to Patient

Name of Insurance Company

Group # _____ Division # _____ ID

**As per our office policies, we do prefer
payment in full upfront at each appointment. We
will however, submit to the insurance company
on your behalf, and they will reimburse you
directly.

Dr. Nenad Vrbancic Dr. Kenny Gryckiewicz Dr. Jona Szakacs

Tel: (403) 263 -7779 Email: info@hillhurstdental.ca

713 14th St NW, Calgary, AB, T2N 2A4



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Patient Name: _____

Physician Name _____ Phone Number _____ Last Checkup _____

1. Are you currently under medical treatment? Y/N
 2. Are you taking prescription or non-prescription medications? If yes, please list the medications.

 3. Have you been hospitalized for any reason in the last 5 years? If yes, please explain.

 4. Do you use controlled or recreational substances? _____
 5. Are you/do you think you may be pregnant? Y/N
- Are you nursing/breastfeeding? Y/N
Are you taking oral contraceptives? Y/N

Please **Check ALL Medical Conditions** You Currently Have or Previously Had.

- | | | |
|---------------------------------------------------|--------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Dental Anxiety | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Liver Failure |
| <input type="checkbox"/> Severe Gag Reflex | <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> Undiagnosed Rash |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Bisphosphonate | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> DVT or Blood Clot | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Autism | <input type="checkbox"/> Addison's Disease |
| <input type="checkbox"/> Hemophilia A or B | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Adrenal Insufficiency |
| <input type="checkbox"/> Von Willebrand Disease | <input type="checkbox"/> Seizure | <input type="checkbox"/> Chron's Disease |
| <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Parkinsons | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Dementia | <input type="checkbox"/> Celiac Disease |
| <input type="checkbox"/> Cardiac Ablation | <input type="checkbox"/> ALS | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Cardiac Stent | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arrythmia | <input type="checkbox"/> Brain Surgery | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Oxygen Tank |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Cardiac Bypass Surgery | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hashimoto's Thyroiditis |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Anemia | <input type="checkbox"/> Recent weight loss |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Lymphedema |
| <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Acid Reflux/ Heart Burn | <input type="checkbox"/> Kidney Transplant |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Kidney Removal |
| <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Dialysis |
| | <input type="checkbox"/> STD | <input type="checkbox"/> Wheelchair |
| | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Vertigo |
| | <input type="checkbox"/> Hepatitis A or E | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Hepatitis B or C | |

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Allergies

Are you **allergic to or have you had any** reactions to:

- | | | |
|---------------------------------------------|--------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Latex | <input type="checkbox"/> Toradol | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Steroids | <input type="checkbox"/> Shellfish |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> NSAIDS |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sedative | <input type="checkbox"/> Adhesives |
| <input type="checkbox"/> General Anesthetic | <input type="checkbox"/> Metals | <input type="checkbox"/> Artificial Dyes |

Other (Please list/describe) _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and or health practitioners.

Cancellation & Credit Card Policy

As per our office policy, we do require 2 business days notice to change or cancel any appointments. Cancellations without the proper notice may be subject to a **\$75.00 fee**. Not showing up for a confirmed appointment will be subject to a **\$100.00 fee**. All patients are required to keep a **valid credit card on file** at all times for any outstanding amounts owing.

I agree to and understand the office policies of Hillhurst Dental Centre.

(Signature) _____ **(Date)** _____