

CONFIDENTIAL MEDICAL HISTORY

Patients Name: _____ DOB (M/D/Y): _____ Phone: _____

Physician's Name _____ Clinic _____

1. Are you in good health? Yes ____ No ____ If no, please provide details _____

2. When was your last medical exam? _____

3. Are you presently receiving treatment for any illness? If yes please provide details _____

4. Have you ever been hospitalized? If yes please provide details _____

5. Do you have heart or circulatory problems? Yes ____ No ____ If yes when _____

Do you have a pacemaker? YES NO

6. Have you ever had rheumatic fever? Yes ____ No ____ If yes, when _____

7. Have you ever been advised to take pre-medication prior to dental treatment? _____

8. Do you have any allergies? Seasonal/Hay Fever _____ Food _____ Medication _____

Other: Please specify _____

9. Are you presently taking any medication? If yes, please specify:

Drug _____ Reason _____

Drug _____ Reason _____

10. Have you ever had a reaction to any medication or dental local anesthetic? If yes please provide details _____

11. Female patients – Are you pregnant or think you may be pregnant: YES NO Breastfeeding: YES NO

12. Have you ever been vaccinated for Human Papillomavirus (HPV)? YES NO

13. Please indicate below if you presently have or have ever had any of the following (please circle):

- | | | |
|----------------------------------|-------------------------|------------------------------------|
| AIDS/HIV | Diabetes | Liver disease (Hepatitis/Jaundice) |
| Alcohol or chemical dependency | Eating disorders | Lung disease/chest pains |
| Arthritis or Rheumatism | Epilepsy/seizures | Mental or nervous disorders |
| Artificial joints or valves | Fainting/Dizzy spells | Stomach ulcers |
| Asthma | High/low blood pressure | Stroke |
| Blood Transfusion | Hyper/Hypo glycemia | Tuberculosis |
| Cancer/radiotherapy/chemotherapy | Kidney disease | Venereal/Communicable disease |

14. Do you smoke? If yes, how many per day? _____ Per Week? _____

15. Do you grind or clench your teeth? Yes ____ No ____

16. Do you suffer from headaches _____ Earaches _____ Neck aches _____

17. Have been outside of Canada within the last 6 months? YES NO If Yes, Where _____

18. Is there any additional information related to your health that has not been addressed above?

Patient or Guardian's Signature

Date

Reviewed By

Date

Welcome to Foothills Dental. Please complete the following important information.

How did you hear about us: Radio? Newspaper? Google? Friend? Other? _____

Patient Contact Information:

Mr / Mrs / Ms / Miss / Dr (Please circle one)

Surname: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Gender: Male / Female DOB M/D/Y: _____

Mailing Address: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____ Emergency Phone Number: _____

Relationship: _____

Responsible Party (For persons under 18 years of age)

Name: _____ Relationship: _____

Address: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance Information:

Primary Insurance Provider: _____

Secondary Insurance Provider: _____

Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this we require your authorization.

"I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to Foothills Dental."



Signature of Patient or Guardian of minor Date

Reason for Visit: _____

Last Dental Visit (date): _____ Treatment: _____

Previous Dentist (name and location): _____

Last set of dental film/xrays (date): _____ Where: _____

Can we request these be sent to our office? _____

Please indicate Yes (Y) or No (N) to the following:

Do your gums bleed while brushing, flossing? ___ Do you bite your lips/cheeks frequently? ___

Are your teeth sensitive to hot/cold? ___ Have you noticed any loosening of teeth? ___

Are your teeth sensitive to sweet/sour? ___ Does food get caught between your teeth? ___

Do you feel pain in any of your teeth? ___ Have you had periodontal (gum) treatment? ___

Have you had oral hygiene instruction? ___

Do you have sores/lumps in/near your mouth? ___ Have you had a difficult extraction? ___

Have you had head/neck/jaw injuries? ___ Have you had prolonged bleeding? ___

Have you experience any of the following?

Clicking? ___ Pain (joint/ear/side of face)? ___ Difficulty opening/closing? ___ Difficulty Chewing ___

Do you have frequent headaches? ___ Do you clench or grind your teeth? ___

Do you wear dentures or partials? YES NO If yes, date placed _____

Do you have any dental implants? YES NO If yes, date placed _____

Have you had treatment from dental specialist? YES NO If yes, what type _____

Additional Comments _____

Foothills Dental Welcomes You!

We would like to officially WELCOME YOU to our dental office and thank you for choosing us as your comprehensive dental care provider.

Our office strives to provide quality, gentle care in a clean, comfortable and relaxed atmosphere. At our office, your complete oral and dental care is our primary focus. We are committed to helping our patients achieve a lifetime of optimum oral health. It is essential to really listen to our patients and understand their needs and desires and to educate them so that they can take an active role in their treatment.

Office financial policies:

1. Many of our patients have dental benefits. While your dental benefit policy is an agreement between you and your insurance company, we will be happy to assist you in preparing and sending in the necessary forms. All professional services are billed directly to you and you are ultimately responsible for payment of the full fee amount. As a courtesy we will accept reimbursement from your insurance company. You will be responsible for any remaining portion the insurance company does not cover. Keep in mind that benefits may not cover 100% of your dentistry, even if you have 100% coverage on your plan. We are glad to assist in helping you understand your dental benefits and getting the most from your plan. Please let us know if your insurance information changes.
2. Appointment times are reserved exclusively for each patient. If for any reason you need to reschedule an appointment, we require two full business days' notice. Another patient who needs our care could be scheduled if we have sufficient time to notify them. Unless an emergency occurs, you can expect us to be on time. We would appreciate the same courtesy. If you are late, we may have to reschedule your appointment so that other patients are not kept waiting. For missed appointments or short notice cancellations a fee may apply.
3. It is the responsibility of each patient to remember the date and time of their appointment. As a courtesy we provide a reminder phone call, two days prior to the appointment. For appointments that have been booked more than two months in advance, we attempt to call two weeks prior to the appointment. We ask that you call us back to confirm the appointment day and time if we were unable to speak to you personally.
4. I understand that all records pertaining to the treatment and diagnosis of are the property of our dental office. Records and X-rays will be duplicated upon request with a customary fee applied for duplication.
5. During the course of my dental care unforeseen complications or new conditions may arise that may affect your original estimate. Every effort will be made to explain any changes to the treatment plan/cost estimate.
6. From time to time it may be necessary to refer you to a specialist so that you may receive the appropriate care. Should this occur, you will be billed directly by the specialist's office.

I understand the above office policies. Furthermore, I consent to the terms of this agreement and all of my questions regarding the office policies have been answered to my satisfaction.

PRINT NAME: _____

WITNESS: _____

SIGNATURE: _____

DATE: _____