New Patient Registration

Living Wellness Dental

PERSONAL INFORMATION

Patient last name : _____ first name : _____ mid name : _____

Your birthday: ____/____/_____ Age:_____ Gender : ☐ Male ☐ Female ☐ Other Email address: _____

Home address: _____ Apt. #: _____ City: _____ Province: _____ Postal Code: _____

Home phone #: (_____) -_____ - Cell Phone #: (_____) - _____ - _____ Work Phone #: (_____) - _____ - _____ Ext: _____

Are there any records or X-rays we should request from your previous dentist? ☐ Yes ☐ No

Previous dentist: _____

Address: _____ Apt. #: _____ City: _____ Province: _____ Postal Code: _____

How did you hear about us ? _____

INSURANCE INFORMATION

Primary Insurance

Card Holder : _____

Insured's Birthday : ____/____/_____

Insurance Co. Name : _____

Group # : _____

ID # : _____

Employer : _____

Secondary Insurance

Card Holder : _____

Insured's Birthday : ____/____/_____

Insurance Co. Name : _____

Group # : _____

ID # : _____

Employer : _____

Signature: _____ Date: _____

Patient Medical History Form

MEDICAL HISTORY

Patient : _____ Date of Birth :____/____/_____

When was your last dental exam? _____ / _____ Dr.'s Name : _____

Teeth professionally cleaned? _____ / _____ Dental x-rays? _____ / _____

When was your last medical examination? _____ / _____ Family Dr. Name : _____

Other Health care practitioners you see :

Name	Telephone
_____	(_____) -_____ - _____
_____	(_____) -_____ - _____
_____	(_____) -_____ - _____

Can we notify them about today's findings to better treat your entire body's needs? ☐ Yes ☐ No

Is your health compromised? ☐ Yes ☐ No

Are you taking any medications now (baby aspirin etc.)? ☐ Yes ☐ No Please list : _____

Are you taking any vitamins or herbal supplements? ☐ Yes ☐ No Please list : _____

Serious illness, hospitalization, or operation in the last 5 years? ☐ Yes ☐ No Please list : _____

Do you use tobacco or vaping products? ☐ Yes ☐ No Amount : _____

Are you pregnant? ☐ Yes ☐ No Are you taking hormonal birth control products? ☐ Yes ☐ No

Are you taking hormone medications? ☐ Yes ☐ No

Have you ever had any of the following:

☐ Heart Disease	☐ Rheumatic/Scarlet Fever	☐ Artificial Joints/Heart Valves	☐ Stroke
☐ Fainting Spells	☐ Diabetes	☐ Hepatitis	☐ Kidney or Liver Disease
☐ Digestive Challenges	☐ Irritable Bowel Syndrome	☐ Colitis	☐ Crohn's Disease
☐ Stomach Ulcers	☐ HIV/ AIDS	☐ Herpes / Cold Sores / Mouth Sores	☐ Asthma/ Breathing Problems
☐ Tuberculosis	☐ Epilepsy/ Seizures	☐ Frequent or Severe Headaches	☐ Neck or Shoulder Pain
☐ Cancer	☐ Radiation Treatment	☐ Nervous/ Mental Disorders	☐ Blood Clots
☐ Osteoporosis	☐ Low Blood Pressure	☐ High Blood Pressure	☐ Alcohol/Drug Abuse
☐ Arthritis	☐ Abnormal Bleeding/ Blood Disorders		☐ None of the above

Have you any allergies to the following?

☐ Antibiotics ☐ Metals ☐ Pain killers ☐ Latex ☐ None

Please list any other drugs / materials that you are allergic to :

_____

Do you have any disease, medical condition or problem not listed above?

_____

TELL US ABOUT YOUR ORAL HEALTH

Are you nervous about visiting our office?	☐ Yes ☐ No	Are you in dental pain right now?	☐ Yes ☐ No
Do you have sensitive teeth?	☐ Yes ☐ No	Do your gums bleed when you brush or floss?	☐ Yes ☐ No
Do you feel you have bad breath?	☐ Yes ☐ No	May we teach you our cure for flossing guilt?	☐ Yes ☐ No
Would you like to know when your teeth are clean enough?	☐ Yes ☐ No	Does your jaw get "stuck", "locked", or "go out"?	☐ Yes ☐ No
Have you ever injured your jaw, head or neck?	☐ Yes ☐ No	Do you ever have pain opening or closing your mouth?	☐ Yes ☐ No

TELL US ABOUT YOUR ORAL HEALTH

Do you clench or grind your teeth?	☐ Yes	☐ No	Are you worried about toxicity of your mercury (grey) fillings?	☐ Yes	☐ No
Are you hard to freeze?	☐ Yes	☐ No	Have you ever had a reaction to local anesthetic?	☐ Yes	☐ No
Are you unhappy with the color of your teeth?	☐ Yes	☐ No	Are you missing any teeth?	☐ Yes	☐ No
Would you like your teeth to be straighter?	☐ Yes	☐ No	Would you straighten your teeth if you didn't need to wear braces?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No	Do you fall asleep easily (while watching TV, during meetings etc.)?	☐ Yes	☐ No
Do you wake up most mornings not feeling refreshed?	☐ Yes	☐ No			

Do you choose fillings based on? (Please list in order of importance the following 1 - More Important, 3 - Less Important) _____ Appearance _____ Durability _____ Cost

What do you do everyday to clean your teeth? _____

Other cleaning aids used & how often? _____

If you could change anything about your smile what would it be?

_____

CONSENT FOR TREATMENT & PRIVACY DISCLOSURE

We are committed to protecting the privacy of your personal information and to utilizing all personal information in a responsible and professional manner. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law. Common ways we use and collect personal information are listed below: Contact information is disclosed to third party health benefit providers and insurance companies when a patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on their behalf. It is also used to invoice for dental services, to collect unpaid accounts or to remind patients concerning the need for further treatment. Financial information may be collected in order to make arrangements for the payment of dental services. Medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. It may also be disclosed to other dentists and/or specialists for procedures to which Living Wellness Dental practitioners may choose to refer them. If selling all or part of our dental practice, qualified potential purchasers may be granted access to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information. Dentists are regulated by the Alberta Dental Association and College which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

☐ This is to certify that I consent to the dental procedures agreed to be necessary or advisable for myself, or my child, including the use of local anesthetic or other drugs as indicated and I will assume responsibility for fees associated with those procedures. I consent to the collection, use and disclosure of my personal information as set out above.

Patient Name: _____ Signature: _____ Date: _____