Last Name_____**First Name**_____**Initial**____

I prefer to be called_____

Gender M□ F□ **Date of Birth:** DD_____/MM_____/YR_____

Married □ Single □ Child □ Other□

Home Address_____

City/Province_____Postal Code_____

Please check preferred contact # □ Home PH_____ □ Work PH_____ext ____
□ Cell PH_____

Would you prefer to receive appointment reminders by EMAIL? Y□ N□

EMAIL_____

Who may we thank for referring you to our practice?

Another patient, friend□ another patient, relative□ Dental Office□ Yellow Pages□ Mail Out/Brochure□ Internet/Website□ Other□

Name of person or office referring you to our practice?_____

Person to contact in **CASE OF EMERGENCY** Relationship to Patient_____

Name_____ Address_____ City / Prov. Postal Code_____

Home PH _____ Work PH _____ Cell PH _____

Person financially responsible for account ***IF Different than patient**

Name_____

Relationship to Patient_____

MEDICAL HISTORY

Name of Medical Doctor_____ PH _____

Alberta Health Care Number _____

Date of Last Visit to medical doctor_____

Current Health Status: Good☐ Fair☐ Poor☐

Have you ever been diagnosed with or treated for any of the following conditions? (Check all that apply)

Do you have a medical condition that requires you to take antibiotics before receiving dental treatment? ☐YES ☐NO

Please list any other serious medical conditions you have or have had in the past:_____

_____

☐ Abnormal Bleeding ☐ Artificial Bones / Joints ☐ Artificial Heart Valves ☐ Alcohol Abuse ☐ Asthma ☐ Cancer ☐ Chronic Cold Sores / Canker Sores ☐ Congenital Heart Defect ☐ Diabetes (takes insulin) ☐ Diabetes (takes oral meds) ☐ Drug Abuse ☐ Emphysema ☐ Epilepsy ☐ Excessive Thirst / Dry Mouth ☐ Fainting Spells ☐ Scarlett Fever ☐ Shortness of Breath	☐ Stroke ☐ Heart Attack ☐ Heart Murmur ☐ Mitral Valve Prolapse ☐ Hemophilia ☐ Hepatitis ∗**specify type**_____ ☐ HIV / AIDS ☐ Kidney Problems ☐ Low Blood Pressure ☐ Psychiatric Problems ☐ Tuberculosis ☐ Non-Epileptic Seizures ☐ Glaucoma ☐ Rheumatic Fever ☐ Anxiety Attacks ☐ Lupus ☐ Other _____	**Have you ever received any of the following medical treatments?** (Check all that apply) ☐ Chemotherapy ☐ I wear a Pacemaker ☐ Radiation ☐ Open Heart Surgery **Are you allergic to any of the following?** (Check all that apply) ☐ Penicillin ☐ Tetracycline ☐ Aspirin ☐ Latex ☐ Erythromycin ☐ Codeine ☐ Sulfa Drugs ☐ Sedatives ☐ Keflex ☐ Nitrous Oxide ☐ Metals ☐ Dental Anesthetics Other:_____ **Do you use tobacco products?** **Y**☐ **how often**_____ **N**☐

Are you taking any of the following? (Check all that apply)

☐ Acetaminophen ☐ Antibiotics ☐ Antihistamines ☐ Aspirin ☐ Blood Thinner ☐ Tranquilizers ☐ Nitroglycerine	☐ Heart Medication ☐ Insulin ☐ Oral Diabetes Medication ☐ Antidepressants ☐ Steroids ☐ Blood Pressure Medicine ☐ Thyroid Medication	**For WOMEN** Are you taking birth control pills? **Y**☐ **N**☐ Are you pregnant? **Y**☐ (week#_____) **N**☐ Are you nursing? **Y**☐ **N**☐

Are you interest in sedation dentistry? ☐ Yes ☐ No

If yes, do you routinely consume grapefruit or grapefruit juice? ☐ Yes ☐ No

St. John's wart? ☐ Yes ☐ No

Could you possibly be pregnant? **Y**☐ **N**☐

CURRENT MEDICATIONS

~ Please provide a detailed list with your specific medications &/or supplements/vitamins you may be taking ~

_____

_____

_____

_____

DENTAL HISTORY

What is your primary concern for today's visit? _____

How often do you brush? _____ How often do you floss? _____

Do you use a power toothbrush? Y□ N□

Do you use a mouth rinse? Y□ (frequency_____ brand_____) N□

Are your teeth sensitive to any of the following?

□ Heat □ Cold □ Sweet □ Pressure

Do you frequently get food caught between your teeth? Y□ N□

Do you experience discomfort in your jaw (TMJ/TMD)? Y□ N□

Previous Dentist: _____

Date of Last Visit: (approximate) _____

Reason for leaving last dentist: _____

What qualities do you like most in a dentist? _____

What qualities do you like least? _____

Are you happy with the way your smile looks? Y□ N□ If no, why not? _____

Would you like whiter teeth? Y□ N□

How would you rate your smile? (Please circle) **1 2 3 4 5 6 7 8 9 10**

WELCOME TO PINNACLE DENTAL

THANK YOU FOR CHOOSING US AS YOUR DENTAL PROVIDER

CONSENT FOR SERVICES

I affirm that the information I have given on this form is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.

As a condition of your treatment by this office, financial arrangements must be made in advance. You will always be informed of your treatment options and financial investment in advance before your treatment begins. Due to the nature of some restorations, or emergency situations, occasionally there may be a need to change your treatment plan during treatment. We respect your finances as much as your health, so if such a change should occur, you will always be notified of the change immediately.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient, and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of 6 months from the date of the patient examinations.

We are committed to protecting the privacy of our patient's personal information & using such information in a responsible & professional manner.
Your ***Contact Information*** is collected to create & update patient files. It may be disclosed to third party health benefit providers and insurance companies for the purpose of claim submission for reimbursement on the patient's behalf.
Financial Information may be collected in order to make arrangements for the payment of dental services.
Medical Information, including radiographs & digital photographs may be disclosed to other dental professionals, dental specialists, and health care providers where the dentist is seeking a 2nd opinion, to assist the dentist in proper treatment planning, or referring the patient for further specialized treatment.

Dentists are regulated by the ADAC (Alberta Dental Association & College) which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

In order to be fair to patients with appointments previously scheduled, and for those in need of urgent/emergency care, I understand Pinnacle Dental has a ***cancellation policy*** which will be enforced with discretion.
A **$30 charge** will be applied to an account when **2 business-days notice** to change a scheduled appointment is not provided.
This will also be applied to those who are excessively late for pre-booked treatment.

I consent to the collection, use, and disclosure of my personal information as set out above.
I have read the above conditions of treatment and payment, and agree to their content.

_____	_____	_____
Signature of patient, parent or guardian	Date	Relationship to patient