Chestermere Smiles DENTAL

Telephone: 403 235 2282
Fax 403 235 2281
info@chestermeresmilesdental.com
22-140 E Chestermere Dr Chestermere AB

Patient Name_____Date_____

Address _____

City _____Postal Code _____

Home Phone_____(B)_____(C)_____

Sex _____Birth Date _____Email Address _____

In case of emergency, contact _____ Phone Number_____

Name of your former Dentist _____ Phone Number_____

YOUR MEDICAL HISTORY

General Physician's Name_____Phone: _____

Approx. Date of Last Exam (if applicable)_____

Are you now under the care of a physician? ☐ Y ☐ N If yes, please explain_____

Have you been admitted to a hospital, or needed emergency care during the past 2 years? ☐ Y ☐ N

If yes, please explain _____

Check if you are allergic to, or have had any reaction to the following

Local Anesthetic	☐	Any Metals (nickel, mercury etc.)	☐
Penicillin (or any other antibiotics)	☐	Latex Rubber	☐
Sulfa Drugs	☐	Sedatives	☐
Codeine	☐	Aspirin	☐

Other (please list)_____

Do you use tobacco? ☐ frequency?_____
Do you use illegal/controlled substances? ☐ frequency?_____

Please list all medications

_____
_____
_____
_____
_____
_____

Do you require pre-med before Dental treatment? ☐ Y ☐ N

Check if you have/had any of the following

☐ High Blood Pressure (Medicated? ☐Y☐N)	☐ Low Blood Pressure	☐ Headaches
☐ Heart Attack	☐ Asthma (Inhaler?☐Y☐N)	☐ Sinus Problems
☐ Rheumatic Fever	☐ Mouth Sores (Herpes)	☐ Heart Murmur
☐ Fainting	☐ Excessive Bleeding	☐ Heart Disease
☐ Diabetes (Insulin? ☐Y ☐N)	☐ Nervous Problems	☐ Sexually Transmitted Disease
☐ Respiratory Problems	☐ Epilepsy/Convulsions	☐ Stomach Problems/Ulcers
☐ Mitral Valve Prolapse	☐ AIDS/HIV Infection	☐ Stroke
☐ Artificial joints/implants/valves/pacemaker	☐ Rapid Weight Gain/Loss	☐ Kidney Disease
☐ Describe_____	☐ Glaucoma	☐ Chest Pains
☐ Hepatitis (Type___)	☐ Psychiatric Care	☐ Thyroid Disease/Malfunction
☐ Tuberculosis	☐ Hay Fever	☐ Cancer (Growths/Tumors) (Chemo? ☐Y ☐N)
☐ Measles	☐ Alcohol/Substance Abuse	☐ Jaundice
☐ Chicken pox		

Are you pregnant? ☐ Y ☐ N | Are you nursing? ☐ Y ☐ N | Are you taking oral contraceptives? ☐ Y ☐ N

YOUR DENTAL HISTORY

What would you like us to do today? _____

Are you in dental discomfort today? ☐ Y ☐ N If yes, when did it start?_____

Approximate date of last dental care_____

Have you ever had an unpleasant dental experience or any complications following treatment?

If yes, please explain _____

Please inform a team member if there is anything we can do to make your visit more comfortable.

Check if you have had problems with any of the following

☐ Bad Breath
☐ Bleeding Gums
☐ Loose Teeth or Broken Fillings
☐ Food Collecting Between Teeth
☐ Grinding or Clenching Teeth
☐ Clicking or Popping Jaw
☐ Orthodontic Treatment

SIGNATURE ON FILE FORM

I understand that my insurance is an agreement between my insurance company and me.

I understand that I am responsible for my balance regardless of my benefits.

I am responsible for keeping track of my annual maximums, frequency restrictions, updating and informing any changes with my insurance to Ellis Dental.

I authorize release of any information and the use of Signature on File, by Ellis Dental relating to and the processing of my Dental Claims.

X_____ X_____
Signed (patient or parent if minor) Witness:

I assign dental benefit payments to be paid directly to Ellis Dental from my insurance company.

X_____ X_____
Signed (patient or parent if minor) Witness:

CREDIT CARD INFORMATION REQUIRED

(OUR OFFICE WILL ACCEPT PAYMENT FROM YOUR INSURANCE, BUT WILL REQUIRE A CC ON FILE)

VISA/M/C, AMEX #_____EXPIRY_____

Patient balances under $100.00 will be charged to CC on file.
(For balances over $100.00, our office will obtain verbal consent from cardholder before charging.)

PATIENT CONSENT

The undersigned hereby authorizes the Doctor to take X-rays (radiographs) study models, photographs or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, therapy and medication that may be indicated in connection with patient and further authorize and consent that the Doctor choose and employ such assistance as is deemed appropriate. I also understand the use of anesthetic agents embodies a certain risk.

X_____ X_____
Patient Signature Date