GROVER DENTAL CENTRE

NAME_____DATE_____

ADDRESS _____POSTAL CODE_____

HOME PHONE _____CELL _____EMAIL _____

WORK PHONE _____EMPLOYER_____

DATE OF BIRTH _____AGE_____

SPOUSE OR PARENTS NAME _____ EMPLOYER _____

PERSON TO CONTACT IN CASE OF EMERGENCY _____PHONE _____

IF STUDENT, NAME OF SCHOOL _____GRADE_____

WHOM MAY WE THANK FOR REFERRING YOU _____

PERSON RESPONSIBLE FOR ACCOUNT _____

SMILE

Previous Dentist's name _____Date of last dental visit_____

Reason for change_____

How can we help you today? _____

Do you like your teeth when you smile? _____

Would you like your teeth whiter? _____

Do your gums bleed when you brush? _____

Do you have or have you ever had any of the following? (Please check if applicable)

- ☐ Teeth sensitive to cold/heat/sweets/pressure
- ☐ Bleeding gums – if yes, how long? _____
- ☐ Food Impaction
- ☐ Clenching or grinding of teeth
- ☐ Frequent headaches
- ☐ Swelling, blisters or lumps in mouth
- ☐ Unusual sound in ear/jaw problems
- ☐ Bad breath/Unpleasant taste
- ☐ Unpleasant dental experience
- ☐ Extraction complication
- ☐ Periodontal (gum) treatment/disease
- ☐ Dentures
- ☐ Orthodontic treatment
- ☐ Root canal treatment
- ☐ Mouth Breathing
- ☐ Oral Habits (nail, cheek or lip biting)
- ☐ Cigarettes/pipe/cigar smoking___/day
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____/day
- ☐ Frequency of dental flossing _____/day
- ☐ Cleaning aids other than brush/floss _____
- ☐ Injury to head, jaw or face
- ☐ Gag easily
- ☐ Fluoride supplements

WE LOOK FORWARD TO SERVING YOU!

To my knowledge, the above information is correct and complete. This is to certify that, I, undersigned, consent to the performing of the dental procedures as agreed to be necessary or advisable, including the use of local or general anesthesia as indicated.

Patient Signature_____ Date_____

(Parent if under 18 years)

MEDICAL QUESTIONNAIRE

The following information is required to enable us to provide you with best possible dental care.
All information is strictly private, and is protected be doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? ☐ YES ☐ NO ☐ NOT SURE/MAYBE
   _____

2. When was you last medical checkup? _____

3. Has there been any change in your general health in the past year? If yes, please explain.
   ☐ YES ☐ NO ☐ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:
   a. Medications ☐ YES ☐ NO ☐ NOT SURE/MAYBE
   b. Latex/rubber products ☐ ☐ ☐
   c. Other. E.g. Hay fever, foods ☐ ☐ ☐

6. Have you ever had a peculiar or adverse reaction to any medications or injection? If yes, please explain.
   ☐ YES ☐ NO ☐ NOT SURE/MAYBE

7. Do you have or have you ever had asthma?
   ☐ YES ☐ NO ☐ NOT SURE/MAYBE

8. Do have or have you ever had any heart or blood pressure problems?
   ☐ YES ☐ NO ☐ NOT SURE/MAYBE

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
   ☐ YES ☐ NO ☐ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint?
    ☐ YES ☐ NO ☐ NOT SURE/MAYBE

11. Have you ever been advised by your doctor to take antibiotics before dental treatment?
    ☐ YES ☐ NO ☐ NOT SURE/MAYBE

12. Do you have any conditions or therapies that could affect your immune system? E.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

13. Have you ever had hepatitis, jaundice, or liver disease?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

14. Do you have a bleeding problem or bleeding disorder?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

15. Have you ever been hospitalized for any illness or operations? If yes, please explain.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

16. Do you have or have you ever had any of the following? Please check.

☐ Chest pain, angina	☐ Prosthetic heart valve	☐ Pacemaker	☐ Steroid Therapy
☐ Diet Pill Therapy	☐ Heart Attack	☐ Lung Disease	☐ Diabetes
☐ Stroke	☐ Shortness of Breath	☐ Drug/Alcohol Dependency	
☐ Seizures (epilepsy)	☐ Kidney Disease	☐ Cancer	☐ Arthritis
☐ Stomach Ulcers	☐ Tuberculosis	☐ Thyroid Disease	

17. Are there any conditions or disease not listed above that you have or have had? If so, what?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

---

18. Are there any disease or medical problems that run in your family? (E.g. diabetes, cancer, or heart disease) ☐ YES ☐ NO ☐ NOT SURE/MAYBE

19. Do you smoke or chew tobacco products?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

20. Are you nervous during dental treatment?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

21. For Women Only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

22. Have you ever been told that you, or anyone with whom you have household contact with, have or have had “MRSA” or “VRE” (either “colonized” or “infected”) or a “superbug”?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

23. Do you currently have an unexplained fever or cough or do you generally feel unwell?
    a. Do you have a pain in your chest? ☐YES ☐NO ☐NOT SURE/MAYBE
    b. Are you coughing up blood or sputum? ☐YES ☐NO ☐NOT SURE/MAYBE
    c. Do you have weakness or fatigue, unexplained weight loss, and/or loss of appetite? ☐YES ☐NO ☐NOT SURE/MAYBE
    d. Do you have chills with your fever? ☐YES ☐NO ☐NOT SURE/MAYBE
    e. Do you have night sweats? ☐YES ☐NO ☐NOT SURE/MAYBE
    f. Do you currently have any of the following Symptoms? (Stuffy nose, Sore throat, Muscle/ Body Aches, Vomiting) ☐YES ☐NO ☐NOT SURE/MAYBE

24. Have you recently been exposed to or do you have a history of TB or influenza (the "flu") disease? If so, please advise of the circumstances.
    ☐YES ☐NO ☐NOT SURE/MAYBE

---

25. Are you being treated for current or recent diarrhea or do you have unexplained diarrhea?
    ☐YES ☐NO ☐NOT SURE/MAYBE

26. Do you have any new uncomfortable symptoms associated with urination?(e.g. pain, blood in urine)
    ☐YES ☐NO ☐NOT SURE/MAYBE

27. Are you being treated for, or do you have a new rash, lesion, break in the skin or pimple-like lesion that has not been diagnosed?
    ☐YES ☐NO ☐NOT SURE/MAYBE

28. Have you ever been diagnosed with CJD (sporadic, familial or latrogenic), Gerstmann-Straussler-Scheinker syndrome (GSS), fatal familial insomnia (FFI) or other prion disease?
    ☐YES ☐NO ☐NOT SURE/MAYBE

29. Do you have any undiagnosed, unusual progressive neurological disease that includes the following:
    a. Dementia or a loss of cognitive ability? ☐YES ☐NO ☐NOT SURE/MAYBE
    b. Myoclonus or an involuntary twitching of a muscle or group of muscles? ☐YES ☐NO ☐NOT SURE/MAYBE
    c. Ataxia or a lack of coordination Of muscle group ☐YES ☐NO ☐NOT SURE/MAYBE

30. Have you had many treatments with antibiotics over the course of your life? If so, please describe.
    ☐YES ☐NO ☐NOT SURE/MAYBE

---

31. Have you ever had chemotherapy or been told that you are immuno-compromised?
    ☐YES ☐NO ☐NOT SURE/MAYBE

32. Have you had any recent exposure to communicable infectious disease? (e.g. measles, chicken pox or tuberculosis)

☐ YES ☐ NO ☐ NOT SURE/MAYBE

33. Do you have a history of joint prosthesis procedures in the last two years?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

34. Have you recently travelled to areas where endemic diseases are present?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

35. Immunization history?

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature_____ **Date**_____

Dentist Signature_____ **Date**_____

INSURANCE

Due to the privacy act, our office cannot obtain pertinent information about your dental plan. Please consider phoning your insurance provider to request the following information so that together we can provide optimum care.

PLEASE ASK YOUR INSURANCE COMPANY THE FOLLOWING QUESTIONS.

1. Does my plan have a yearly maximum? ☐ YES ☐ NO $_____
2. Is my insurance on a rolling year? Starting month_____

   -OR-

   Is my insurance on a calendar year? (JAN1-DEC31)? _____

SCALING

1. How many units of scaling/root planning are allowed per year? _____ is it a rolling year? _____ if yes, is it 6/9/12 months_____ **OR** is it calendar year? _____
2. How often is polish and fluoride covered? _____
3. Is there an age limit on fluoride? _____

CHECKUPS AND XRAYS

How often are the following procedures covered?

1. New Patient Exams _____
2. Recall Exams ADULTS_____ CHILDREN_____
3. X-rays (bitewings) ADULTS_____ CHILDREN_____
4. Is there a limit on x-rays (e.g. 15 x-rays in a 3 years period_____
5. Panoramic X-rays_____

You may also want to request information on what % is covered for basic, major and orthodontics. For orthodontics, you will need to ask if there is an age limit, and if there is a maximum separate from the maximum previously mentioned. We appreciate your help in obtaining this information.

INFORMED CONSENT FOR DENTAL TREATMENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health.

In order to help formulate treatment recommendations, the following **DIAGNOSTIC PROCEDURES** may be performed: 1) a medical and dental history, 2) x-rays, 3) examination of the mouth and associated structures, 4) stone models of the teeth, 5) intra-oral photographs, and 6) conference with previous or concurrent treating health professionals. If additional diagnostic procedures or consultations are indicated, they will be discussed with you.

TREATMENT RECOMMENDATIONS are based on information gained from initial diagnostic procedures and previous experience and may vary for similar situations. We will discuss with you the most appropriate and ideal treatment as well as reasonable alternative treatment plans. We will also inform you of the likely dental prognosis if no treatment is initiated at this time. You are welcome at any time to seek a second opinion.

All dental and anesthetic procedures have **ASSOCIATED RISKS**. These may be, but are not limited to:

1. Drug reactions and side effects.
2. Damage to adjacent teeth or fillings.
3. Post-operative infection.
4. Post-operative bleeding that might require additional treatment.
5. Delayed healing of an extraction site (dry socket) necessitating additional care.
6. Sinus involvement during removal of upper molars which may require additional treatment or surgical repair at a later date.
7. Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue or other areas.
8. Bruising, swelling, sensitivity, or pain.
9. Breakage of dental instruments inside tooth canals making additional treatment necessary.
10. Complications during treatment necessitating referral to a specialist.

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fees involved have also been explained. All of my questions have been answered, and I have not been offered any guarantees.

Patient Signature _____ **Date** _____

Witness _____ **Date** _____

Grover Dental Centre

202 - 46 Carry Drive S.E.
Medicine Hat, AB T1B 4E1
Ph. 403-526-7555

Dental Office Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses (collectively referred to as "Contact Information"). Contact Information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment.
- To send patients informational material about our dental practice.

Contact Information is disclosed to third-party health benefit providers and insurance companies where the 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 the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments (collectively referred to as "Medical Information"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed:

- To third-party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the costs of dental treatment or has asked us to submit a claim on the patient's behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process, 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.

I consent to the collection, use and disclosure of my personal information as set out above.

_____	_____	_____
Date	*Print Name*	*Signature*

Grover Dental Centre

Payment Consent
Grover Dental Centre

It has been explained to me, and I understand that the fees for my dental treatment may not be covered by or may exceed my insurance plan benefits. I understand and agree that I am financially responsible to my dentist for the entire cost of treatment. Therefore, if the amount due for my treatment exceeds what my insurance will cover, I agree that I am required to pay the difference. If however, my insurance actually pays more than the estimate provided at the time of my treatment, then Grover Dental Centre will credit my account for this difference.

As well, I understand that my dental insurance is a private matter between myself and my insurance provider, and that my insurance provider, due to the requirements of personal privacy legislation, will not share with nor discuss any of my policy's information with the dental office. Therefore, I am responsible for understanding the coverage limits and details of my dental insurance policy, and that I may also be required to communicate directly with my insurance provider should there be any questions or concerns.

It has also been explained to me and I understand that I am required to pay for treatment once it has been completed and at the end of my appointment.

Please note that Grover Dental Centre will accept payment by cash, Visa, MasterCard, American Express, or by InterAc debit card. However, we do not accept personal cheques.

_____	_____	_____
Date	*Print Name*	*Signature*

EMAIL FORMS PRINT FORMS