Patient Information (Confidential)

Name_____ Birth date _____

Home Phone_____ Work Phone _____ Cell Phone _____

Address _____ City _____ Province _____ Postal Code _____

Email _____ How were you referred to us _____

Alberta Health Care Number _____ Parent/Guardian name if minor: _____

Occupation_____ Employer _____

Emergency Contact_____ Phone#_____

Family Doctor _____ Phone # _____

Insurance Information

Insurance Company _____ Insurance Company _____

Group/ Policy_____ ID/ cert# _____ Group/Policy_____ ID/cert_____

Insurance ☐self ☐ Spouse ☐Child Insurance ☐ self ☐ Spouse ☐ Child

Name of Policy Holder _____ Name of Policy Holder _____

Policy Holder Date of Birth _____ Policy Holder Date of Birth _____

Do you have any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure----------	☐	☐	Heart Disease----------	☐	☐	Chest Pains----------	☐	☐
Heart Attack----------	☐	☐	Cardiac Pacemaker----------	☐	☐	Easily Winded----------	☐	☐
Rheumatic Fever----------	☐	☐	Heart Murmer----------	☐	☐	Stroke----------	☐	☐
Swollen Ankles----------	☐	☐	Angina----------	☐	☐	Hay Fever/Allergies----------	☐	☐
Fainting/Seizures----------	☐	☐	Frequently Tired----------	☐	☐	Tuberculosis----------	☐	☐
Asthma----------	☐	☐	Anemia----------	☐	☐	Radiation Therapy----------	☐	☐
Low Blood Pressure----------	☐	☐	Emphysema----------	☐	☐	Glaucoma----------	☐	☐
Epilepsy/Convulsions----------	☐	☐	Cancer----------	☐	☐	Recent Weight Loss----------	☐	☐
Leukemia----------	☐	☐	Arthritis----------	☐	☐	Liver Disease----------	☐	☐
Diabetes----------	☐	☐	Joint Replacement or Implant------	☐	☐	Heart Trouble----------	☐	☐
Kidney Diseases----------	☐	☐	Hepatitis/Jaundice----------	☐	☐	Respiratory Problems---------	☐	☐
AIDS or HIV Infection----------	☐	☐	Sexually Transmitted Disease------	☐	☐	Mitral Valve Prolapse---------	☐	☐
Thyroid Problem----------	☐	☐	Stomach Troubles/Ulcers----------	☐	☐	Other----------	☐	☐

Have you had a sleep study completed? _____ When: _____ Where: _____

Have you been diagnosed with **Sleep Apnea** or other **Sleeping Disorder**? _____

Please list Allergies or Allergic Reactions you have had:

_____

Please list all medications:

_____

Women Only:	Yes	No		Yes	No
Are you pregnant or think you may be pregnant?	☐	☐	Are you taking oral contraceptives?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I understand that I am responsible to pay for any treatment provided and that my insurance company will send reimbursement directly to me not the dentist. I agree to be responsible for the payments of all services rendered on my behalf or my dependents.

X_____ Date_____

Signature of patient or Parent of minor