GLENBROOK DENTAL

Personal Information

Title: ____ Name: Last_____ First_____ Middle_____

Preferred Name: _____ Sex: _____ Pronoun (if you wish to specify):_____

Birthday: (DD/MM/YY) _____/_____/_____

Home Address: _____

City: _____ Province:_____ Postal Code: _____

Occupation: _____

Email Address: _____

Phone Mobile: _____ Home: _____ Work: _____

PARENT/GUARDIAN INFORMATION (If patient is a minor)

Title: ____ Name: Last_____ First_____ Middle_____

Preferred Name: _____

(If different from above)

Home Address: _____

City: _____ Province:_____ Postal Code: _____

Phone: Mobile: _____ Home: _____ Work: _____

Your Preferred Method of Contact (please check at least one): ◯ **Phone** ◯ **Email** ◯ **Text** ◯ **No Preference**

How did you hear about our office? (ie. Google, Friend, Family) _____

INSURANCE INFORMATION (Please fill out if known or applicable)

Policy Holders Name _____ Policy Holders Date of Birth (DD/MM/YY)_____

Name if Insurance Company: _____

Group or Policy Number: _____ ID/Certificate Number: _____

Employer: _____

Medical History

Yes **No** Are you currently being treated for any medical condition?

If yes, please specify the reason _____

Yes **No** Do you have any allergies?

If yes, please list your allergies _____

Yes **No** Have you ever been told to take antibiotics before your dental appointment?

If yes, please specify the reason _____

Name of Your Family Physician and Medical Clinic _____

Please List all Current Medications, Non Prescription Drugs, Supplements

Name of Medication	Reason for Taking Medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please circle "YES" to any of the following that apply to you

Yes	**No**	Diabetes	**Yes**	**No**	Infectious diseases (AIDS/HIV/Hep A,B,C)
Yes	**No**	High blood pressure	**Yes**	**No**	Artificial heart/heart valve
Yes	**No**	Low blood pressure	**Yes**	**No**	Cardiac transplant
Yes	**No**	Liver disease	**Yes**	**No**	Bacterial endocarditis
Yes	**No**	Kidney disease	**Yes**	**No**	Congenital heart disease/defect
Yes	**No**	Thyroid disease	**Yes**	**No**	Artificial joint
Yes	**No**	Stroke/Heart Attack	**Yes**	**No**	Pacemaker
Yes	**No**	Seizures	**Yes**	**No**	Asthma
Yes	**No**	Bleeding disorders	**Yes**	**No**	Shortness of breath
Yes	**No**	Cancer	**Yes**	**No**	Lung disease/tuberculosis
Yes	**No**	Arthritis	**Yes**	**No**	Stomach problems
Yes	**No**	Osteoporosis	**Yes**	**No**	Steroid therapy
Yes	**No**	Anxiety	**Yes**	**No**	Radiation/Chemotherapy
Yes	**No**	Depression	**Yes**	**No**	Drug/alcohol dependency
Yes	**No**	Other mental/psychological condition	**Yes**	**No**	Smoke/chewing tobacco

Yes **No** WOMEN ONLY: Are you currently pregnant or nursing? What is your delivery date?

_____

If necessary, please elaborate on any of the above answered "YES" or if you have a condition not listed above, please note it below:

_____

_____

_____

_____

Dental History

Yes **No** Do you currently have a specific dental concern(s) you would like addressed? If Yes, please specify._____
_____

Approximately when was your last…
Dental checkup? _____ Dental cleaning? _____
Dental x-rays? _____

Name of previous Dental office and Dentist _____

Do you have of the following?
Yes **No** Bleeding gums when brushing/flossing
Yes **No** Been told you have gum disease
Yes **No** Sensitive teeth

Yes **No** Been told you clench/grind your teeth
Yes **No** Clicking or popping in the jaw
Yes **No** A nightguard

Yes **No** Have you ever had trouble with dental freezing?
Yes **No** Have you had other complication or issues with previous dental treatment? If Yes, please specify.
_____
Yes **No** Are you nervous during dental treatment? If Yes, please specify.
_____

Yes **No** Are you currently happy with your smile? If No, what specifically are you unhappy with?
_____
Yes **No** Have you had interest in orthodontics (ie. braces) or invisalign treatment?

Is there a specific dental topic you would like more information about or would like us to discuss with you?

◯ Sedation Options (ie. laughing gas, oral sedation)
◯ Extractions (including wisdom teeth)
◯ Teeth Whitening
◯ TMJ treatment
◯ Gum grafting
◯ Dental Implants
◯ Dentures
◯ Veneers
◯ Cosmetic bonding
◯ Deep cleaning

General Consent

General Consent for Dental Treatment

I authorize the dentist to perform all diagnostic procedures including and not limited to x-rays and photographs, as may be required to determine necessary treatment, and to perform necessary or advisable treatment.

Personal Information

I understand that the collection of my personal information is necessary for the following purposes:

- Opening and updating patient files
- To invoice patients for dental services, process credit card payments, collect unpaid payments
- Process claims for payment from third party insurance/benefits providers
- Contact me with regards to treatment, appointments and news regarding our practice
- Providing proper and safe dental treatment with respects to my medical health which may include providing information to other dental specialists or medical providers

I understand that Glenbrook Dental will collect, use and disclose this information in accordance with the Law under the Canadian Personal Privacy Act as well as the regulations outlined by the Alberta Dental Association and College. By signing this, I consent to the collection, use and disclosure of my personal information for the reasons outlined above.

Cancellation Policy

We understand that sometimes you need to reschedule your appointment and ask that you provide us with notice 2 business days prior to your appointment. By signing this, I understand that if insufficient notice is given, a fee may be applied.

Insurance and Billing

We extend the courtesy of sending your insurance claims electronically. Due to the Canadian Personal Privacy Act, the details of your dental plan are kept confidential therefore we cannot access this information.

I understand that I am responsible for knowing the details of my dental plan including annual plan maximums, frequencies and all other limitations. **If you have any questions regarding your insurance plan, please ask our administrative staff and we would be more than happy with assist you.**

I have read and understand all of the above policies and have provided accurate information to the best of my knowledge.

_____ _____

Patient or Guardian Signature Date