ADe DENTAL

Patient Personal Information

Last Name: First Name: Preferred Name:

Birthdate: Male ( ) Female ( )

Address:

City: Province: Postal code:

Home # ( ) Cell # ( ) Work # ( )

Email: Alberta Health Card:

How did you hear about us?

Health History:

1. Have you had a medical examination in the last year? ---------- Yes / No

2. Have you ever been advised to take antibiotics prior to dental appointments ---------- Yes / No

3. Have you been hospitalized for any injury or surgery?

4. Are you taking or have previously taken as Bisphosphonate medications?

5. Have you ever had an allergic reaction to any medications, foods etc?
If Yes, please list:

Please list all medications you are taking including vitamins, supplements and herbal medicines:

FOR WOMEN ONLY: Are you or could you be pregnant? ---------- Yes / No

Please circle if you have or have had any of the following:

Allergies/Hives	Cortisone/Steroid meds	Organ Transplant
Angina	Diabetes	Psychiatric Disorders
Anemia /Sickle Cell Disorder	Drug/Alcohol Dependency	Radiation/Chemotherapy
Artificial Heart Valve	Epilepsy/Seizures	Sinus Trouble
Artificial Joints	Fainting/Dizzy Spells	Stomach Problems
Asthma/Emphysema	Heart Disease/Attack	Stroke
Arthritis/Rheumatism	Heart Failure/Murmur	Thyroid Disease
Blood Disorders/ Hemophilia	Heart Surgery/Pacemaker	Tuberculosis (TB)
Bruise easily	Hepatitis A/B/C	Ulcers
Cancer	HIV/AIDS	Undiagnosed Skin Rash
Cold Sores/Herpes	High / Low Blood Pressure	Venereal Disease
Congenital Heart Problems	Liver Disease / Jaundice	Osteoporosis

If you have any disease, condition or problem not mentioned above, please list:

Medical Doctor name: Ph:

Dental History:

When was your last dental visit? Last X-rays:

Do you have any swelling or bleeding of the gums?

Do you have any pain? Hot or cold sensitivity?

How often do you brush? Floss?

Do you smoke or chew tobacco? How many/often:

Do you clench or grind your teeth? Nail biting?

What is your primary dental concern:

ADx DENTAL

Dental Benefits Information

Primary Insurance:

Subscriber Name:	Subscriber date of birth:
Insurance carrier/company:	Group/Contract Number:
ID/Certificate Number:	Patient Relationship to Subscriber:

Secondary Insurance:

Subscriber Name:	Subscriber date of birth:
Insurance carrier/company:	Group/Contract Number:
ID/Certificate Number:	Patient Relationship to Subscriber:

Assignment of Benefits/Fees and Payment:

Would you like us to where possible direct bill to your insurance provider ---------- Yes / No

If yes, we require a valid credit card on file for security. Please advise our team and they will provide you the additional form.

I understand that I am fully responsible for the total fee at the time of service and I have chosen to assign my benefits, payable to ADx Dental and acknowledge that the patient portion (or estimated patient portion is due at the time of service. Or entire balance if I have opted to not direct bill to my benefits provider is due at the time of service.

Signature: Date:

If no, we will still submit your claims electronically on your behalf.

All short notice cancellations (less that 48hrs notice) and all no-show appointments may be subject to a $75.00 fee.

Signature: Date:

This is to certify that I, _____consent to the performing of the dental and oral surgery procedures agreed to be necessary or advised, including the use of local anesthetics as indicated and I will assume responsibility for fees associated with those procedures including those fees which are not covered by any insurance I may be covered by at any given time. I agree that the information provided is true to best of my knowledge.

_____ _____ Parent ( ) Guardian ( )

Signature Date (please check if applicable)