HorizonDental

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PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Name (First, Last) _____ Preferred name _____

Birth date (DD/MM/YYYY)_____ If minor, parents' names _____

Home phone _____ Work phone _____ Cell phone _____

Email _____ Alberta Health number: _____

Mailing address _____ City _____ Prov _____ Postal Code _____

Employer _____ Occupation _____

Spouse's name _____ ❑ Not married Gender ❑ Female ❑Male

How did you hear about us? ❑ Phonebook ❑ Internet ❑ Family/friend referral (name)_____

❑Other _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance ❑1 insurance ❑ 2 insurances

First Insurance:

Subscriber's name (First, Last): _____ Date of birth (DD/MM/YYYY) _____

Insurance company: _____ Group/Policy #_____

Certificate/ID number _____ Employer:_____

Secondary Insurance: ❑ yes ❑ no

Subscriber's name (First, Last): _____ Date of birth (DD/MM/YYYY) _____

Insurance company _____ Group/Policy# _____

Certificate/ID number _____ Employer: _____

WE COMPLY WITH ALL PRIVACY ACT, RULES AND REGULATIONS

Insurance: Please be reminded that your Dental Plan is a contract between you, your employer and the insurance company. We do not control the fees they will pay according to, or the restrictions on your plan. We encourage you to be very well informed of all your plan details. **Knowing your plan restrictions and maximums is very important – Please track and record this information as we cannot always track for you.** Most insurance companies have their own fee schedule (and every plan and insurance company fees vary greatly) in which they pay according to; each dental office also has their own fees.

I understand that the dental office collects my dental coverage information as a guideline ONLY to assist me in maximizing my benefits. This does not hold them responsible for my account._____(**Initia**l)

I agree to pay all unforeseen balances within 10 days from the date of statement._____(**Initial**)

Cancellation Policy: I understand that I need to provide at least 48 hours notice should I need to reschedule an exiting appointment so that the clinic can accommodate other patients. _____ (**Initial**)

Treatment consent: I, the undersigned, authorize Horizon Dental Group to perform necessary dental services that I may need during my diagnosis and treatment with my informed consent. I understand I am responsible for all fees associated with my dental treatment, even if a dental plan is involved.

Print Name: _____ Date: _____

Signature: _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (Please check any that apply)

- ☐ Hospitalization for illness or injury
- ☐ Heart problems, or cardiac stent within the last 6 months
- ☐ History of infective endocarditis
- ☐ Artificial heart valve, repaired heart defect (PFO)
- ☐ Pacemaker or implantable defibrillator
- ☐ Orthopedic implant (joint replacement)
- ☐ Rheumatic or scarlet fever
- ☐ High or low blood pressure
- ☐ A stroke
- ☐ Anemia or other blood disorder
- ☐ Prolonged bleeding due to a slight cut
- ☐ Emphysema, shortness of breath, sarcoidosis
- ☐ Tuberculosis, measles, chicken pox
- ☐ Asthma
- ☐ Breathing or sleeping problems (sleep apnea, snoring, sinus)
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Jaundice
- ☐ Thyroid, parathyroid disease or calcium deficiency
- ☐ Hormone deficiency
- ☐ High cholesterol or taking statin drugs
- ☐ Diabetes (HbA1c=_____)
- ☐ Stomach or duodenal ulcer
- ☐ Digestive disorders (celiac disease, gastric reflux)
- ☐ Osteoporosis/osteopenia (i.e. taking bisphosphonates)
- ☐ Arthritis
- ☐ Autoimmune disease
- ☐ Glaucoma
- ☐ Head or neck injuries
- ☐ Epilepsy, convulsions (seizures)
- ☐ Neurologic disorders (ADD/ADHD, prion disease)
- ☐ Viral infections and cold sores
- ☐ Any lumps or swelling in the mouth
- ☐ Hives, skin rash, hay fever
- ☐ STI/HPV
- ☐ Hepatitis (type _____)
- ☐ HIV/AIDS
- ☐ Tumor, abnormal growth
- ☐ Radioation therapy
- ☐ Chemotherapy, immunosuppressive medication
- ☐ Psychiatric treatment
- ☐ Antidepressant medication
- ☐ Alcohol or recreational drug use

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Aspirin, ibuprofen, acetaminophen, codeine
- ☐ Penicillin or other antibiotics
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Sulfa drugs
- ☐ Local anesthetic
- ☐ Fluoride
- ☐ Metals (nickel, gold, silver)
- ☐ Latex materials
- ☐ Other:_____

Are you (please check all that apply):

- ☐ Aware of a change in your health in the last 24 hours (Fever, chills, new cough or diarrhea)
- ☐ Taking medication for weight management
- ☐ Taking dietary supplements
- ☐ Often exhausted or fatigued
- ☐ Experiencing frequent headaches
- ☐ Considered a sensitive person
- ☐ Often unhappyor depressed
- ☐ Taking birth control pills
- ☐ Currently pregnant Expected delivery date: _____
- ☐ Diagnosed with prostate disorder

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Name of your physician:_____

Most recent physical examination: (DD/MM/YYYY) _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possible affect your dental treatment. (Botox, Collagen injections) _____

Please list all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____

Please advise us in the future of any change in your medical history or any medications you may be taking.

Signature of patient (or parent) _____ Date _____