centennialsmiles dental

new patient form

Unit #245 – 520 3rd Ave SW, Calgary, AB T2P 0R3 • (587) 317-7959

Title:_____Given Name:_____Pronunciation:_____

Surname:_____ Preferred Name:_____

Address:_____ Address 2:_____

Province:_____ City:_____ Postal Code:_____

Date of Birth:_____ Gender:_____ Email:_____

Home #_____ Work # _____Contact Method: _____

Occupation:_____ Employee/School: _____

Are you available for Short Notice Appointments?: Yes ❑ No ❑ Emerg Contact: _____ Emerg Phone: _____

Emerg Relation: _____If you were referred to us, who referred you?: _____

Dental Information

In the following section, please select whichever applies. You answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during you initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions conceming your health.

Do your gums bleed when brushing or flossing?	Yes ❑ No ❑	Do you bite your lips or cheeks frequently?	Yes ❑ No ❑
Have you ever had Orthodontic (braces) Treatment?	Yes ❑ No ❑	Do you have headaches or migraines?	Yes ❑ No ❑
Are your teeth sensitive to cold, hot, sweets, or pressure?	Yes ❑ No ❑	Have you had any difficult extractions in the past?	Yes ❑ No ❑
Do you feel pain to any of your teeth?	Yes ❑ No ❑	Ever worn a bite plate or other appliance?	Yes ❑ No ❑
Do you have any sores or lumps in your mouth?	Yes ❑ No ❑	Have you ever had difficulty opening or closing your jaw?	Yes ❑ No ❑
Have you ever had a head, neck, or jaw injury?	Yes ❑ No ❑	Have you had any pain in your jaw area?	Yes ❑ No ❑
Do you have any loose teeth or have they ever shifted?	Yes ❑ No ❑	Have you ever had Periodontal Treatment (gums)?	Yes ❑ No ❑
Does food frequently get caught in your teeth?	Yes ❑ No ❑	Have you ever been tested for Sleep Apnea?	Yes ❑ No ❑
		Have you ever had a CPAP machine or sleep appliance?	Yes ❑ No ❑

If you have a current dental problem, please describe: _____

Do you have any other concerns about having dental treatment? Yes ❑ No ❑ If so, please explain; _____

_____

Are you happy with the appearance of your teeth? Yes ❑ No ❑ If not, please explain: _____

_____

Please give a brief discription of your oral hygiene habits: _____

Please enter your previous dentist's name and location: _____

Do you ever feel nervous about visiting the dentist? Yes ❑ No ❑ If so, please explain: _____

_____

Date of your last dental x-ray _____ Date of your last teeth cleaning: _____ Date of your last dental exam _____

What can we do to make you smile? Check all that apply and we'll get back to you with more information about your inquiry:

- ❑ Veneers
- ❑ Gummy Smiles
- ❑ White Fillings
- ❑ Oral Concious Sedation
- ❑ Total Smile Makeovers
- ❑ Replace Metal Fillings
- ❑ Neuromuscular Dentistry
- ❑ Replace Missing Teeth
- ❑ Correct Misaligned Teeth
- ❑ Instant Orthodontics
- ❑ Cosmetic Dentures
- ❑ Sleep Apnea/Snoring
- ❑ Broken/Cracked Teeth
- ❑ Dental Implants
- ❑ Eliminate Gaps
- ❑ Invisalign Teeth Straightening
- ❑ 1 Hour In-0ffice Whitening
- ❑ Rejuvinate Worn/Stained Teeth

Medical Information

Dental professionals primarly treat the area in and around your mouth, but since your mouth is part of your body, any medication you are taking and your health history have a important relationship with your dental treatment. Please answer the following questions.

Are you currently seeing a Family Physician? Yes ❑ No ❑
If yes, please enter their name, phone number, and the date your of last visit._____

_____

Have you ever had a serious head or neck injury? Yes ❑ No ❑

If so, please explain. _____

_____

Have you recently (in the last two years) been hospitalized or had a major operation? Yes ❑ No ❑

Please explain. _____

Date of your last physical exam: _____

Are you or could you be pregnant? Yes ❑ No ❑ If yes, what is the expected delivery date?_____ Taking birth control pills? Yes ❑ No ❑

Please go over the following section and indicate which of the following you have or have had. If you need to add any further information, please enter it at the end.

AIDS/HIV Positive	Yes ❑ No ❑	Chest Pains	Yes ❑ No ❑	Hemophilia	Yes ❑ No ❑
Alzheimer's Disease	Yes ❑ No ❑	Circulation Problems	Yes ❑ No ❑	Hepatitis A	Yes ❑ No ❑
Anaphylaxis	Yes ❑ No ❑	Diabetes	Yes ❑ No ❑	Hepatitis B or C	Yes ❑ No ❑
Anemia	Yes ❑ No ❑	Emphysema	Yes ❑ No ❑	High Blood Pressure	Yes ❑ No ❑
Arthritis/Gout	Yes ❑ No ❑	Epilepsy/Seizures	Yes ❑ No ❑	Kidney Problems	Yes ❑ No ❑
Artificial Heart Valve	Yes ❑ No ❑	Fainting	Yes ❑ No ❑	Liver Disease	Yes ❑ No ❑
Artifical Joint	Yes ❑ No ❑	Glaucoma	Yes ❑ No ❑	Lung Disease	Yes ❑ No ❑
Asthma	Yes ❑ No ❑	Head or Neck injuries	Yes ❑ No ❑	Mental/Nervous Disorder	Yes ❑ No ❑
Blood Disease	Yes ❑ No ❑	Heart Attack/Failure	Yes ❑ No ❑	Organ/Medical Transplant	Yes ❑ No ❑
Bruise Easily	Yes ❑ No ❑	Heart Murmur	Yes ❑ No ❑	Sickle Cell Disease	Yes ❑ No ❑
Cancer	Yes ❑ No ❑	Heart Pacemaker	Yes ❑ No ❑	Stroke	Yes ❑ No ❑
Chemotherapy	Yes ❑ No ❑	Heart Surgery	Yes ❑ No ❑	Tuberculosis	Yes ❑ No ❑

Please enter details or any further information.

Please list any prescription or non-prescripton medicine you are currently taking or have recently taken.

Are you allergic to have you had a reaction to any of the following items?

Barbiturates, Sedatives or Sleeping Pills	Yes ❑ No ❑
Antibiotics	Yes ❑ No ❑
Aspirin	Yes ❑ No ❑
Codeine	Yes ❑ No ❑
Darvon	Yes ❑ No ❑
Local Anaesthetic	Yes ❑ No ❑
Nitrous Oxide	Yes ❑ No ❑

Other

If you have ever been advised against taking any type of medication, please list them below.

If you have any allergic conditions please list them below. This can include asthma, hay fever, food allergies, and metal or latex allergies.

Do you use any form of tobacco or wear a nicotine patch?	Yes ❑ No ❑
Are you dependent on alcohol or drugs?	Yes ❑ No ❑
If so, have you received treatment?	Yes ❑ No ❑
Have you ever tested HIV positive?	Yes ❑ No ❑
Do you bruise easily or bleed severely when you are cut?	Yes ❑ No ❑
Do you have severe earaches, ear or throat infections, or headaches?	Yes ❑ No ❑
Do you wear eyeglasses or contact lenses?	Yes ❑ No ❑

Children Only

Please list any medical conditions or illnesses the child has recently had.This can include measles, strep throat, tonsillitis

Insurance Information

Primary Insurance

Subscriber Name: _____

Subscriber Date Of Birth _____

Relationship: _____

Insurance Name: _____

Policy Number: _____

Policy Description: _____

Subscriber ID#: _____

Division Number: _____

Secondary Insurance

Subscriber Name: _____

Subscriber Date Of Birth _____

Relationship: _____

Insurance Name: _____

Policy Number: _____

Policy Description: _____

Subscriber ID#: _____

Division Number: _____

Cancellation Policy

Please know that appointment times have been reserved especially for you, and any change in the schedule affects many people. If for any reason you are unable to keep the reserved appointment time, we ask the courtesy of two business days' notice to allow us to offer the time to another client who may be waiting for an opening. Appointments cancelled with less than two business days' notice may be subject to a broken appointment fee, amount of the fees is dependent on the length of the appointment.

_____ Please Initial

Fees And Credit Card Authorization

Credit Card Number	Expiry Date	Security Code	Signature

Name	Date	Signature

Electronic Claim Authorization

I understand that Centennial Smiles Dentistry (Tasneem Rhemtulla Professional Corporation) has invested in the technology to submit my claims electronically and I authorize release, to my dental benefit carrier, imformation contained in claims submitted electronically.

Name	Date	Signature

Personal Information Patient Consent

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 us "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 the reminders to the 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 is collected for payment processing purposes. it is not shared with third parties without your consent, unless permitted by law for outstanding bill collection purposes.

We collect information from our patients about their health history, their family health history, physical condition and dental treatments. (Collectively referred to us "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 cost of dental treatment or has asked us to submit a claim on the patient's behalf.
- With the consent of the patient, to other dentists and dental specialists, or to other health care professionals.
- 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 step 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.

Name _____

Signature _____ **Date** _____

X-ray And Records Release Consent

Patient's Name_____Birthdate _____

Family Members to Transfer (I f Applicable) _____

Previous Dental Office:

I, _____, herby authorize and request the release of x rays and records to be transferred to Centennial Smiles Dental.

Patient's/Parent's Signature: _____ Date:_____

Please send all recent x-rays to:

info@centennialsmiles.ca • Centennial Smiles • 245, 520 3rd Ave SW, Calgary AB, T2P 0R3

COVID-19 Pandemic Dental Treatment Consent Form

Patient name: _____

I understand the novel coronavirus causes the disease known as COVID-19. I understand the novel coronavirus virus has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____ (Initial)

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a dental office. _____ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 identified by Alberta Health Services:

- Fever > 38°C _____ (Initial)
  Recorded Temperature:_____
- New cough or worsening chronic cough _____ (Initial)
- Sore throat or painful swallowing _____ (Initial)
- New or worsening shortness of breath _____ (Initial)
- Difficulty Breathing _____ (Initial)
- Flu-like symptoms _____ (Initial)
- Runny Nose _____ (Initial)

I confirm I know that there are categories of people who are considered to be high risk. I understand the high risk category factors are being 65 years of age or older, heart disease, lung disease, kidney disease, diabetes or any auto-immune disorder. _____ (Initial)

OR

I fall into the following high risk categories (_____) and my dentist and I have discussed the risks, and I have agreed to proceed with treatment. _____ (Initial)

I confirm that to my knowledge I am not currently positive for the novel coronavirus. _____ (Initial)

I confirm I am not waiting for results of a laboratory test for the novel coronavirus that was ordered due to contact tracing or because I had identified risk factors. _____ (Initial)

Please note: Any individual who has gone in for testing on their own volition as an asymptomatic individual does not need to indicate that.
I verify that I have not returned to Alberta from any country outside of Canada whether by car, air, bus, boat or train in the past 14 days. _____ (Initial)

I understand that any travel from any country outside of Canada, including travel by car, air, bus, boat or train, significantly increases my risk of contracting and transmitting the novel coronavirus. Alberta Health Services require self-isolation for 14 days from the date a person has returned to Canada. _____ (Initial)

I understand that Alberta Health Services has asked individuals to maintain physical distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive dental treatment. _____ (Initial)

I verify that I have not been identified as a contact of someone who has tested positive for novel coronavirus or been asked to self-isolate by Alberta Health, the Communicable Disease Control or any other governmental health agency. _____ (Initial)

OR

I verify that I am a healthcare worker who has worn appropriate PPE. _____ (Initial)

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the above listed dental treatment completed during the COVID-19 pandemic.

_____
SIGNATURE OF PATIENT

Printed Name_____ Date_____