WELCOME TO OUR OFFICE

Patient Name: _____ Date of Birth: (dd/mm/yy) _____/_____/_____ Sex: _____

Address: _____ City: _____ Postal Code: _____

Home Number: _____ Work Number: _____ Cell Number: _____

Emergency Contact Number:_____ Email:_____

Family Physician: _____Health Services Number: _____Marital Status: _____

Occupation: _____ Name of Employer: _____

Insurance Provider: _____ Policy Number: _____ ID Number:_____

Whom may we thank for referring you? Name: _____

Medical History

Have you ever had any of the following? Please check those that apply:

- ○ AIDS
- ○ Anemia
- ○ Arthritis/Rheumatism
- ○ Artificial Joints
- ○ Asthma
- ○ Blood Disease
- ○ Cancer
- ○ Diabetes
- ○ Dizziness
- ○ Epilepsy/Seizures
- ○ Fainting
- ○ Glaucoma
- ○ Hay Fever
- ○ Head Injuries
- ○ Heart Disease
- ○ History of infective endocarditis
- ○ Hepatitis
- ○ High/Low Blood Pressure
- ○ High Cholesterol
- ○ Jaundice
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mental Disorders
- ○ Multiple Sclerosis
- ○ Radiation Treatment or Chemotherapy
- ○ Respiratory Problems or Lung Disease
- ○ Congenital Heart Disease
- ○ Rheumatic Heart Disease
- ○ Sinus Problems
- ○ Stomach Problems
- ○ Stroke
- ○ Thyroid problems
- ○ Tuberculosis
- ○ Tumors
- ○ Ulcers
- ○ Osteoporosis
- ○ Venereal Disease
- ○ Codeine Allergy
- ○ Penicillin Allergy
- ○ Prosthetic Cardiac Valves

Women Only:

- ○ Are you pregnant? Due Date_____
- ○ Are you trying to get pregnant
- ○ Birth control pills or other hormonal contraceptives

Do you:

- Smoke or chew tobacco? ___Y ___N If yes how often? _____ Alcoholic Beverages per/week_____
- Recreational Drug Use past or present? ___Y ___ N
- Do you have any allergies? If yes, please explain: _____
- Have you ever had an allergic reaction to medication? If yes, please explain:_____
- Have you ever had any complications following dental treatment, or with local or general anaesthetic?
  If yes, please explain: _____
- Do you bleed abnormally? ___Y ___N
- Have you been admitted to a hospital or needed emergency care during the past 5 years? ___Y ___ N
  If yes, please explain: _____
- Have you had a medical examination within the last year? ___Y ___ N
  Are you under the care of a physician/specialist for an ongoing medical condition? ___Y ___N
  If yes, please explain: _____

Medications:

Please list any medications you are taking (prescription, non-prescription, herbal, etc.) Or provide a copy from your Pharmacy.

_____

_____

_____

Dental History

- Reason for today's visit: ___Exam ___Cleaning ___Emergency ___Other _____
- How often do you visit the dentist? ___6 months ___Yearly ___ Emergency only

Do you have, or ever had any of the following:

- o Bridges/Crowns
- o Partial Dentures
- o Full Dentures
- o Root Canal
- o Dental Implants
- o Lost Fillings
- o Extractions
- o Loose teeth
- o Orthodontic Treatment
- o Bite Adjustment
- o Bite appliance/Night guard
- o Swelling/pain in face or jaw
- o Surgery in your mouth
- o Gum treatments
- o Difficulty opening or closing your jaw
- o Radiation therapy to head or neck

Check any of the following you are interested in or you have thought about:

- o Orthodontics (braces)
- o Bonding (straightening)
- o Close spaces between teeth
- o Replacing missing teeth
- o Repairing chipped teeth
- o Bleaching (Whitening teeth)
- o Crowns or bridges
- o Improved breath odor
- o Improved gum health
- o Improving your bite
- o Sports mouth guard
- o Improving your smile

- Do you chew on only one side of your mouth? If so, why? _____
- Have you experienced any growth or sore spots in your mouth? If so, where? _____
- Would you rate your current dental health as: ___Excellent ___Good ___Fair ___Poor
- Do you have any concerns regarding your dental visit?
  ___Fear ___Pain ___Time ___Money ___Embarrassment ___Other concerns_____

Terms of Service

1. Cancellation of your appointment time with less than 24 hours notice may result in fee being charged for the missed visit.
2. Services shall be paid for at each visit as services are performed. Please understand that all dental services provided are charged directly to you, and that you are personally responsible for payment of all dental services rendered to you or to minor patients for whom you are requesting care or are the legal guardian of. If you carry insurance, although our office will try to assist you with completion of dental insurance forms and collection from insurance companies, we will not accept an assignment of your insurance proceeds.
3. Interest of 2% per month (24% per annum) will be charged on the unpaid balance on all accounts exceeding 30 days.

_____
Initial

Electronic Communication

☐ Please check this box if you wish to allow Swift Current Family Dental Associates – Dr. Curtis Argue D.M.D. Prof. Corp. and Dr. Melinda Klassen Dental Prof. Corp. to send you appointment reminders, updates, or other office communications via text message or email.

In order to comply with the **Personal Information Protection and Electronic Documents Act** and the **Health Information Protection Act,** Swift Current Family Dental Associates – Dr. Curtis Argue D.M.D. Prof. Corp. and Dr. Melinda Klassen Dental Prof. Corp. require you to complete and sign the following:

I consent to the collection, use and disclosure of my personal information as disclosed on this form and provided to you in or as a result of my office visits for the following purposes:

- To provide me with dental health services;
- For matters related to my dental insurance;
- To maintain personal, verbal or electronic communication and provide me with the information and follow up respecting my dental care;
- To maintain communication in the event of a dental health emergency;
- To obtain payment of my account with your office;
- For the uses, purposes and disclosure required by law;
- For the uses, purposes and disclosure described in the Privacy Policy as amended from time to time.
  Other_____

Patient Printed Name: _____

Patient Signature_____ Date_____

*Patient Legal Guardian or Proxy Signature: _____
*(if patient is a minor or has a legal guardian or other substitute health care decision maker)