Aspira Dental

#105 – 501 Bethel Drive, Sherwood Park, AB T8H 0N2 **P:** (780) 467-8822 **F:** (780) 467-8803

Patient Information

Title (Circle one) Mr. Mrs. Ms. Dr. Marital Status _____ Male ☐ Female ☐

Name: First _____ Initial _____ Last _____

Preferred Name _____ Date of Birth (DD/MM/YYYY) _____/_____/_____

Address _____

City_____ Province _____ Postal Code _____

Employer/School _____ Occupation _____

Phone H (_____) _____ W (_____) _____ C (_____) _____

Email_____How did you hear about our office?_ _____

Physician Name _____ Telephone Number _____

Alberta Health Care# _____

Emergency Contact _____ Telephone Number _____

Insurance Information

Primary Insurance Company _____ Secondary Insurance Company _____

Policy Holder Name _____ Policy Holder Name _____

Date of Birth (DD/MM/YYYY)_____/_____/_____ Date of Birth (DD/MM/YYYY) _____/_____/_____

Group/Policy/Plan # _____ Group/Policy/Plan # _____

I.D./Certificate # _____ I.D./Certificate # _____

Relationship to Patient _____ Relationship to Patient _____

Medical History

1. Have you ever had a serious illness or condition requiring hospitalization or extensive medical care?
   If Yes, Please Specify _____
2. Are you currently under the care of a physician?
   Please Specify _____
3. Do you take any prescription or non-prescription drugs regularly?
   Please specify _____
   Do you take any **BLOOD THINNERS**? ☐ Yes ☐ No Please specify_____
4. Have you ever experienced unusual reactions to any of the following?
   ☐ Penicillin ☐ Local Anesthetic ☐ Aspirin ☐ Codeine ☐ Sulpha Drugs ☐ Latex ☐ Other
   Please explain _____
5. Do you have AIDS or have you ever tested positive for H.I.V.? _____
6. Have you ever had an injury, surgery, or radiation therapy to your head, face, jaw, or neck?
   If Yes, Please Specify_____
7. Women only: Are you currently pregnant or suspect you might be?
   If so, how many weeks? _____ Are you nursing? YES ☐ NO ☐
8. Have you had any organ transplants or **medical** implants? YES ☐ NO ☐
9. Do you experience shortness of breath or chest pain when walking or climbing stairs? YES ☐ NO ☐

PLEASE COMPLETE REVERSE SIDE

Do you currently experience, or have you ever had any of the following? Please check/circle all that apply:

☐ Angina	☐ Drug/Alcohol Dependency	☐ Hyper/ Hypo Glycemia	☐ Sinus Problems
☐ Arthritis/ Rheumatism	☐ Epilepsy/Seizures	☐ High/Low Blood Pressure	☐ Stomach Problems/ Ulcers
☐ Asthma	☐ Fainting	☐ Joint Replacement	☐ Stroke
☐ Blood Thinners	☐ Frequent Headaches	☐ Kidney Problems	☐ Swelling of Ankles
☐ Bruise Easily	☐ Glaucoma	☐ Liver Disease	☐ Thyroid Disorder
☐ Cancer/ Chemotherapy	☐ Heart Disease	☐Lung Disease/Emphysema	☐ Tuberculosis
☐ Cold Sores	☐ Heart Murmur	☐ Mental/Nervous Disorder	☐ _____
☐ Cortisone/Steroid Therapy	☐ Hepatitis A/B/C	☐ Sexually Transmitted Disease	☐ _____

Please elaborate on any of the above:

_____

_____

Previous Dental History

1. Former Dentist _____ Last Visit Date _____
2. Do you have a specific concern you would like addressed?
   If Yes, Please describe _____
3. How often do you brush your teeth? _____
4. How often do you floss your teeth? _____
5. Are your teeth sensitive to: Hot ☐ Cold ☐ Sweets ☐ Biting and/or chewing ☐
6. Do your gums bleed easily? YES ☐ NO ☐
7. Are you aware of an unpleasant taste in your mouth or bad breath? YES ☐ NO ☐
8. Do you smoke?
   If Yes, How many years have you smoked? _____ How many per day? _____
9. Do you experience any tightness, clicking or pain in the jaw joint? YES ☐ NO☐
10. Do you clench or grind your teeth? YES ☐ NO ☐
11. Do you bite your nails or suck your thumbs or fingers? YES ☐ NO ☐
12. What cosmetic changes would you make to your teeth?
    Straighten ☐ Whiten ☐ Improve Shape ☐ Other ☐ _____
13. If you recently had surgery or will be having surgery, do you require premedication for dental treatment?
    Please Specify type of surgery _____
14. On a scale of 1 to 5 how nervous do you feel coming to the dentist? NOT AT ALL 1 2 3 4 5 VERY

I certify that I have provided an accurate and complete personal and medical/dental history to Aspira Dental and have not knowingly mislead or omitted any information. I have had the opportunity to ask questions and fully understand all of the questions on this form. I authorize the dentist to perform diagnostic procedures and treatment as necessary for proper dental care. I understand that consultation with my medical doctor may be required and I consent to my physician being contacted if necessary. I authorize the free exchange of information between Aspira Dental and my dental insurance agency including contact information, coverage, treatment planned and completed.

_____ _____

Signature of Patient / Parent / Guardian Date

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Cancellation Policy

To provide the best care and services to our patients, **we require a 48 hour notice for any cancellations or rescheduling of appointments. Any cancellations or rescheduling of appointments given less than 48 hours' notice will be subjected to a charge, dependent on the length of appointment.** Providing prior notice will help us accommodate patients who are requesting to come in sooner for treatment.

We understand emergency situations may happen which are unavoidable, please don't hesitate to let us know so we may re-evaluate this policy.

Financial Policy

We will gladly accept payment from your insurance company should your plan allow direct payment to the dental office.

Your dental benefits plan has its own fee guide, set by the plan administrator. The eligible fees stipulated in this guide may accommodate our fee, or it may be less than our fee. **If the eligible fee stated in your plan is lower than the fee charge, you are responsible for your percent portion plus the difference in fees. Even if you have dual coverage under two plans, the fee guide difference may not allow for full coverage.**

As a service to our patients, we offer electronic claims submissions on the date of your treatment to plans that accept this method. If your insurance plan responds with your portion amount, payment of your portion must be made at that time. For your convenience, we accept cash, Debit, Visa, and MasterCard. We do not accept AMEX at this time. **If your insurance plan does not provide this information at the time of your visit, we require a deposit of your estimated portion and ask that you provide a credit card number so any remaining balance owing can be applied after we received payment from your plan.**

☐ Visa ☐ MasterCard _____ Expiry ___/____ Security __ __ __

Before the charges are applied, we will always call to advise you of any remaining balances. Please let us know the appropriate contact number to reach you.

Telephone Number_____

Insurance is a reason to smile, but do not let it determine your health. We will always recommend the most appropriate treatment for your dental health, and sometimes this may not fall under the coverage your plan provides. Upon request, a written estimate will be provided to you for the treatment planned. If you are uncertain about your dental insurance coverage, our office can send a pre-determination of benefits directly to your insurance company before any services are provided. We provide this service at no cost to you.

Ultimately, it is your responsibility to understand your plan details.

I have read and understood the financial and cancellation policies and options at Aspira Dental. I have been given an opportunity to ask questions, and they have answered to my satisfaction. My signature below confirms my agreement and understanding of the above statements and policies. I authorize Aspira dental to perform diagnostic procedures as may be required to determine necessary treatment. I assume all responsibility for the fees associated with my dental treatment and/or dental diagnostic procedures. I authorize the free exchange of information between Aspira Dental and my dental insurance agency including contact information, coverage, treatment planned and completed.

X _____ _____

Signature Date