Canyon Meadows
Dental Care

11646 Elbow Dr. SW
Calgary, Alberta T2W 1S8
(403) 278 3400 Fax: (403) 278 3458

Patient Information

(Please print clearly)

Last Name _____ First Name _____ Initial _____

Marital Status _____ Date of Birth D/ M/ Y _____

Alberta Health Care # _____

Home Address _____

City _____ Province _____ Postal Code _____

Home Phone No. _____ Cell No. _____

Work Phone No. _____ Occupation _____

Email Address _____

*Who may we thank for referring you to our office? Location, Yellow pages, Welcome Wagon, Other _____

In case of emergency, whom should we notify?

Name: _____ Name of family doctor: _____

Relationship: _____ Phone number of family doctor: _____

Daytime phone: _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical conditions at the present or have you been treated within the past year?

If so why? ◯ Yes ◯ No ◯ Not sure

2. When was your last medical checkup? _____

3. Have there been any changes in your general health in the past year?

If yes, please explain. ◯ Yes ◯ No ◯ Not sure

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?

If yes, please list. ◯ Yes ◯ No ◯ Not sure

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5. Do you have any allergies? If yes, please provide list using the categories below.

a) Medications: _____

b) Latex/rubber products: _____

c) Other (food, hay fever, etc.): _____

6. Have you ever had a peculiar or adverse reaction to any medicines, anesthesia or injections?

If yes, please explain. ◯ Yes ◯ No ◯ Not sure

7. Have you ever been advised by your doctor to take antibiotics before dental treatment?

If yes, please explain. ◯ Yes ◯ No ◯ Not sure

8. Do you smoke or use other tobacco products? ◯ Yes ◯ No ◯ Not sure

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

- ☐ Angina
- ☐ Arthritis or rheumatism
- ☐ Artificial joint
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Chest pain
- ☐ Creutzfeldt–Jakob disease
- ☐ Diabetes
- ☐ Diet pill therapy
- ☐ Drug or alcohol addiction
- ☐ Heart attack/Heart disease
- ☐ Epilepsy or seizures
- ☐ Heart murmur
- ☐ Hepatitis A/ B/ C
- ☐ High/Low blood pressure
- ☐ HIV positive
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Mental or nervous disorder
- ☐ Mitral valve prolapse
- ☐ MRSA
- ☐ Pacemaker
- ☐ Prosthetic heart valve
- ☐ Scarlet or rheumatic fever
- ☐ Sexual transmitted infection
- ☐ Shortness of breath
- ☐ Sinus Problems
- ☐ Steroid therapy
- ☐ Stomach/intestinal problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ VRSA

If you have checked any of the above, please provide details.

_____

_____

_____

_____

_____

Women Only - Are you pregnant, breastfeeding or trying to get pregnant? ◯ Yes ◯ No
If you are pregnant, what is your expected delivery date? _____

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Are you experiencing any of the following? (Please check all that apply)

- ☐ Toothache
- ☐ Bleeding Gums
- ☐ Receding Gums
- ☐ Painful Gums
- ☐ Loose Teeth
- ☐ Bad Breath
- ☐ Painful Wisdom Teeth
- ☐ Grinding Teeth
- ☐ Mouth Breathing
- ☐ Thumb Sucking
- ☐ Snoring
- ☐ Lip Biting
- ☐ Food Wedging Between Teeth
- ☐ Popping / Painful / Clicking Jaw Joint
- ☐ Lumps / Swelling / Ulcers in the Mouth
- ☐ Feel tired, fatigued, or sleepy during daytime
- ☐ Someone has noticed you stop breathing during sleep

Are your teeth sensitive to: (Please check all that apply)

☐ Cold ☐ Heat ☐ Biting Pressure ☐ Brushing ☐ Sweets

WHAT IS YOUR PRESENT CONCERN ABOUT YOUR MOUTH OR TEETH?

_____

_____

_____

_____

Have you had any problems with previous dental treatment? If so, what? ◯ Yes ◯ No

_____

When was your last dental visit? _____

What was done? ☐ Checkup ☐ Cleaning ☐ Filling ☐ Toothache ☐ Other

Have you ever had any injury, surgery or x-ray therapy to the face, head, neck, mouth or jaws? ◯ Yes ◯ No

Do you brush your teeth ☐ at least 2x daily ☐ 1x daily ☐ sometimes

Are you concerned about the appearance of your teeth or your smile? ◯ Yes ◯ No

I am concerned about: (Please check all that apply)

☐ Dental crowding ☐ Tooth color ☐ Tooth shape ☐ Tooth size ☐ Apperance of gums ☐ Comfort of the bite ☐ Comfort of the Jaw Joint

☐ Other _____

Consent:
I authorize the dental personnel to perform services for prevention and treatment of dental disease using the procedures and medications required, and I assume responsibility for the fees associated with those procedures.
I authorize Canyon Meadows Dental Care to submit my insurance claim electronically on my behalf.

Date _____ Print Name _____ Signature _____