Welcome to Our office! Kindly complete your Confidential Patient Information

PERSONAL INFORMATION

Name: _____ Preferred Name: _____
Last First Initial

Date of Birth: (d /m /y) Male □ Female □ Single □ Married □ Child □ Other □

Address: _____ City: _____ Postal: _____

Cell Phone: _____ Home Phone: _____ Bus Phone: _____

E-Mail Address: _____

Family Physician: _____ Telephone: _____

Emergency Contact Name & Number: _____

Occupation: _____

How did you hear about our office? _____

INSURANCE INFORMATION

Primary Insurance Information

Name of Insured: _____ DOB: _____ Employer: _____

Name of Insurance Co: _____ Policy# _____ ID# _____ Div# _____

Secondary Insurance Information

Name of Insured: _____ DOB: _____ Employer: _____

Name of Insurance Co: _____ Policy# _____ ID# _____ Div# _____

Print Patient Name: _____ **Date:** _____

Signature: _____

ULTIMA DENTAL WELLNES
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DENTAL HISTORY

Patient Name_____ Nickname_____ Age_____

Referred by_____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist_____ How long have you been a patient?_____ Months/Years

Date of most recent dental exam____/____/____ Date of most recent x-rays____/____/____

Date of most recent treatment (other than a cleaning)____/____/____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE			
7.	Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE			
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT			
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS			
33.	Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change(shape, color, size, display)?	☐	☐
34.	Have you ever whitened (bleached) your teeth?	☐	☐
35.	Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature_____ Date _____

Doctor's Signature_____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

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

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex _____		
☐ nuts _____		
☐ fruit _____		
☐ milk _____		
☐ red dye _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) _	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high blood pressure	☐	☐
10. low blood pressure _____	☐	☐
11. stroke (taking blood thinners) _____	☐	☐
12. anemia or other blood disorder _____	☐	☐
13. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
14. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
15. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
16. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
17. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _	☐	☐
18. kidney disease _____	☐	☐
19. liver disease or jaundice _____	☐	☐
20. vertigo (e.g. "the room is spinning") _____	☐	☐
21. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
22. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) _____	☐	☐
23. high cholesterol or taking statin drugs _____	☐	☐
24. diabetes (HbA1c = _____) _____	☐	☐
25. stomach or duodenal ulcer _____	☐	☐
26. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
27. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
28. arthritis or gout _____	☐	☐
29. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
30. glaucoma _____	☐	☐
31. contact lenses _____	☐	☐
32. head or neck injuries _____	☐	☐
33. epilepsy, convulsions (seizures) _____	☐	☐
34. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
35. viral infections and cold sores _____	☐	☐
36. any lumps or swelling in the mouth _____	☐	☐
37. hives, skin rash, hay fever _____	☐	☐
38. STI/STD/HPV _____	☐	☐
39. hepatitis (type____) _____	☐	☐
40. HIV/AIDS _____	☐	☐
41. tumor, abnormal growth _____	☐	☐
42. radiation therapy _____	☐	☐
43. chemotherapy, immunosuppressive medication _____	☐	☐
44. psychiatric treatment or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD diagnosis _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

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

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.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

OFFICE POLICIES

Ultima Dental Wellness is hereby authorized to maintain the "Patient(s)" financial information in its records in order to make arrangements for payment of dental services from the Patient's benefits provider(s). Ultima Dental accepts assignment of dental benefits for the Patient's convenience. Ultima Dental requires that the Patient provide valid and current credit card information to be maintained on the Patient's file. Ultima Dental agrees not to disclose credit card information to third parties or to use credit card information unless authorized by the Patient to do so. The patient hereby agrees that amounts owing after payment of insurance benefits will be charged to the Patient's credit card unless alternate arrangements are made and agreed to by both Parties.

With regard to dental health benefit plans, it should be realized that the plan is between the benefits company and the employee (i.e. patient) and as such the details of coverage are unknown to Ultima Dental. Ultima Dental will attempt to estimate the cost of the proposed treatment as accurately as possible. **However, in the event of a discrepancy between the estimated cost and the actual cost of the treatment, the difference will be the responsibility of the account holder.**

When an estimate is requested, Ultima Dental will be as accurate as possible. Unfortunately, dental treatment complications cannot be entirely foreseen and hence differences between estimates and actual costs can arise. Once again, the difference will be the responsibility of the account holder.

CANCELLATION POLICY

If it becomes necessary to cancel an appointment, I understand that 48 hours notice is required for cancellation of that appointment. There will be a **$75 per hour fee** for missed or no-show appointments which will immediately be charged to my credit card without further notice.

Agreed and accepted this _____ day of _____, 20_____.

Signature of Patient_____

Personal Information Consent Form

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, home & work telephone numbers, and email addresses. Contact information is collected and used for the following purposes:

- To open & 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 reminders to patients concerning the need for further dental examinations 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 may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. (Collectively referred to as "Medical Information") Patients' Medical Information is collected and used for the purpose for 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 patients' behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

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 steps to ensure that the prospective purchaser safeguards all personal information.
Dentists are regulated by the Alberta Dental Association and College which may inspect or 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

Date_____ Print name_____ Signature_____