Ultima DENTAL wellness
#202, 506 – 71 Avenue SW, Calgary, Alberta T2V 4V4
info@ultimadentalwellness.ca
(403) 259 – 3401

NEW PATIENT, DENTAL & MEDICAL HISTORY FORM

PERSONAL INFORMATION							
Last Name		First Name		Initial		Preferred Name	
Birthday		Male ☐	Female ☐	Single ☐	Married ☐	Child ☐	Other ☐
Address				City		Postal Code	
Cell Phone				Home Phone			
Bus Phone		Extension		E-Mail			
Family Physician				Telephone			
Emergency Contact Name				Emergency Contact Number			
Occupation							
How did you hear about our office?				Other			

INSURANCE INFORMATION							
Primary Insurance Information							
Name of Insured			Birthday		Employer		
Name of Insurance Co		Policy #		ID #		Div #	
Secondary Insurance Information							
Name of Insured			Birthday		Employer		
Name of Insurance Co		Policy #		ID #		Div #	

DENTAL HISTORY					
How would you rate the condition of your mouth?	Good ☐	Fair ☐	Poor ☐	Previous Dentist	
Date of most recent dental exam			Date of most recent x-rays		
What is your immediate concern?					

PLEASE CHECK TO ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS:

PERSONAL HISTORY	
1. Are you fearful of dental treatment?	☐
2. Have you had an unfavorable dental experience?	☐
3. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐
4. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐

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GUM AND BONE	
5. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐
6. Have you ever noticed an unpleasant taste or odor in your mouth?	☐
7. Is there anyone with a history of periodontal disease in your family?	☐
8. Have you ever experienced gum recession?	☐
TOOTH STRUCTURE	
9. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐
10. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐
11. Do you have grooves or notches on your teeth near the gum line?	☐
12. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐
13. Do you frequently get food caught between any teeth?	☐
BITE AND JAW JOINT	
14. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐
15. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐
16. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐
17. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐
18. Are your teeth developing spaces or becoming more loose?	☐
19. 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?	☐
20. Do you place your tongue between your teeth or close your teeth against your tongue?	☐
21. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐
22. Do you clench or grind your teeth together in the daytime or make them sore?	☐
23. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐
24. Do you wear or have you ever worn a bite appliance?	☐
SMILE CHARACTERISTICS	
25. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐
26. Have you ever whitened (bleached) your teeth?	☐
27. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐
28. Have you been disappointed with the appearance of previous dental work?	☐

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MEDICAL HISTORY					
Name of Physician					
Most recent physical examination					
How would you rate your current physical health?	Good ☐	Fair ☐	Poor ☐		
DO YOU HAVE or HAVE YOU EVER HAD:					
1. Hospitalization for illness or injury?					☐
2. An allergic or bad reaction to any of the following:					☐
Aspirin ☐	Codeine ☐	Penicillin ☐	Erythromycin ☐	Sulfa ☐	Local Anesthetic ☐
Metals (Nickel, Gold, Silver)					
Latex ☐	Peroxide ☐	Iodine ☐	Other ☐		
3. Heart problems, or cardiac stent within the last six months?					☐
4. Artificial heart valve, repaired heart defect (PFO)?					☐
5. History of infective Endocarditis?					☐
6. Pacemaker or implantable defibrillator?					☐
7. Orthopedic or soft tissue implant (e.g joint replacement, breast implant)?					☐
8. Heart murmur?					☐
9. Rheumatic or scarlet fever?					☐
10. High blood pressure?					☐
11. Low blood pressure?					☐
12. Stroke (taking blood thinners)?					☐
13. Anemia or other blood disorder?					☐
14. Prolonged bleeding due to slight cu (INR 3.5)?					☐
15. Kidney disease?					☐
16. Liver disease or jaundice?					☐
17. Thyroid, parathyroid disease, or calcium deficiency?					☐
18. Diabetes? (if yes which type)					☐
19. Viral infections and cold sores?					☐

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20. Hepatitis? (if yes which type)	☐
21. HIV/AIDS?	☐
22. Radiation therapy, cancer, or chemotherapy?	☐
ARE YOU:	☐
23. Are you presently being treated for any other illness?	☐
24. Are you a smoker?	☐
25. Do you have Glaucoma?	☐
26. Do you have sleep problems? (if yes please elaborate)	☐
27. Are you taking birth control pills?	☐
28. Are you currently pregnant?	☐
29. Currently nursing?	☐

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 Name 1		Purpose	
Drug Name 2		Purpose	
Drug Name 3		Purpose	
Drug Name 4		Purpose	

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Print Patient Name		Date	
Signature			

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_____