VULCAN DENTAL

NEW PATIENT FORM

Your cooperation in completing this form is essential to provide you with safe and appropriate dental care.

All information is strictly **confidential**.

Name: _____ Preferred Name: _____

Gender: _____ This Patient is an: Adult ☐ Child ☐

Mailing Address: _____

City: _____ Province: _____

Postal Code: _____ Date of Birth: _____

Employer: _____ Email: _____

Phone (Cell): _____ Work Phone: _____

Whom may we thank for referring you to our clinic? _____

How would you prefer to be contacted for notifications or reminders of appointmets?

Phone ☐ Text ☐ Email ☐

If you have a dental benefits plan, please present your information to the front desk.

Our clinic will be pleased to direct bill your insurance company on your behalf. However, knowledge of your specific insurance plan coverage including maximums and anniversary date is **your responsibility**. _____ *initial here*

Preauthorization can be sent to the insurance carrier when requested by the patient. _____ *initial here*

Insurance payments must be provided within 60 days. If carrier does not provide payment, the patient is responsible for payment and must seek reimbursement from their insurance. _____ *initial here*

Patients without coverage or who do not honour assignment, must provide full payment on the date of appointment. _____ *initial here*

x _____ _____

(*Signature*) (*Date*)

Patient ☐ Parent ☐ Guardian ☐

This is to certify that I, the undersigned, consent to the performing of the dental and oral procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with those procedures. In the pressence of insurance, I authorize the handling of my insurance exchange of information by Vulcan Dental. Interest may incur if outstanding balances are left unpaid for greater than 30 days. It may be necessary to charge for time lost if an appointment is missed without prior notification.

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MEDICAL HISTORY

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Physician's Name: _____

Emergency Contact: _____ Relation To You:_____

Emergency Phone: _____ Preferred Pharmacy: _____

Alberta Health Card: _____

1. Are you presently, or within the last 6 months been under the care of a physician for any condition or serious ailment? NO YES

Please explain: _____

_____

2. Has there been any change in your health in the last year? NO YES

_____

3. Do you have any bleeding disorder or are you on any blood thinners? NO YES

_____

4. Have you ever been or are you currently on any Bisphosphonate drugs for conditions such as osteoporosis: NO YES List Drug: _____

5. Have you had a replacement or repair of a heart valve, heart transplant, infection of the heart or a congenital heart defect? _____

6. Do you have any prosthetic or artificial joints? _____

7. Do you have any allergies you are aware of? _____

8. Women Only: Taking birth control Nursing Pregnant How many weeks? _____

Do you have any of the following medical conditions:? (check all that apply)

☐ Asthma	☐ Bleeding Problems	☐ Cancer
☐ Diabetes Type 1 or 2	☐ Heart Attack	☐ Heart Murmur
☐ Hepatitis	☐ High Blood Pressure	☐ HIV+
☐ Kidney Disease	☐ Liver Disease	☐ Osteoporosis
☐ Psychiatric Treatment	☐ Rhematic Fever	☐ Stroke

Please provide us with a list of current medications you are on.

_____

It may be neccessary to contact your phsyician or pharmacist to aid in your dental treatment.

I hearby state this information is current and true to my knowledge:_____

(signature) *(date)*

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DENTAL HISTORY

Your cooperation in completing this form is essential to provide you with safe and appropriate dental care.

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Reason for today's visit: _____

Approximate last dental visit: _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Are you aware of any clenching or grinding habits that you may have? YES NO

Any clicking or locking of the jaw? YES NO

Do you have a history of head or facial trauma? YES NO

Are you aware of any lumps, growths or sore spots in your mouth? YES NO

Please rate how nervous you are during dental treatment?

1 Never 2 Minimally 3 Moderately 4 Very 5 Extremely

Any other dental concerns? _____

Have you had any dental x-rays taken within the last year? YES NO

Please select any treatments you are interested in learning more about:

- ☐ White Fillings
- ☐ Crowns/Veneers
- ☐ Dental Bridges
- ☐ Dental Implants
- ☐ Teeth Whitening
- ☐ Oral Sedation
- ☐ Complete Denture
- ☐ Partial Denture
- ☐ Extraction(s)
- ☐ Cleaning
- ☐ Exam
- ☐ Nitrous Sedation
- ☐ Night Guard
- ☐ Root Canal
- ☐ Bonding
- ☐ Invisalign
- ☐ Desensitizing teeth