Vitality Oral Health

Patient Information

Please print. If you need assistance with this form, please ask our staff.

Patient Full Name: ______________________ Preferred Name: ______________

Birthdate: MM/DD/YYYY: ______________ Email address: ______________________

Street Address: ______________________ City: ______________

Province: __________ Postal Code: ______________ AHC #: ______________

Mobile #: ______________ Home #: ______________ Preferred #: Mobile / Home

Medical Decisions made by: Self / Legal Guardian / POA

Guardian / POA Name: ______________________ Phone Number: ______________

Emergency Contact Name: ______________________ Relationship: ______________

Emergency Contact #: ______________________ Referred by: ______________

Please provide a copy of any dental insurance information or fill out the following:

Private Insurance Carrier: ______________________ Policy/Group #: ______________

ID/Certificate #: ______________________ Insured under: Self / Other

If insured by other:
Insured Name: ______________ Insured Birthdate: ______________ Relationship: __________

AISH/AB WORKS #: ______________________

Consent and use of Personal Information:
We are committed to protecting the privacy of our patient's personal information and will utilize any information collected in a responsible and professional manner, according to Alberta Privacy Laws. If you choose to be contacted by email, please be aware that there are inherent limits to protecting your privacy.

Payment Policies:
We are pleased to provide direct billing to MOST insurance companies. We often receive the response immediately to verify submission. Please be advised that you are responsible for paying any outstanding amounts not covered by your private insurance and their designated fee guide at the end of your appointment. We are happy to provide treatment estimates or insurance pre-determinations upon request. We accept all forms of government insurance, including NIHB, ADSC/AISH, and AB Works. If you do not have insurance, you will be required to pay for the full cost of treatment the day of treatment.

Cancellation Policy:
Your time is important to us, and we are pleased to reserve scheduled time for you. Missed or cancelled appointments increase the wait time for all our patients. We ask that you please provide at least 48 hours' notice to change or cancel appointment. A fee of $100 per hour may be charged for missed or short notice cancellations which will be billed to you directly, as insurance companies will not cover this fee.

X ____

Patient / Guardian / POA Signature Date

Please complete medical and dental history on reverse side.

Medical History

1. Chief Complaint (Why are you here?): ______________________________

2. Approximate weight: __________________ Approximate height: __________________

3. Have you been a patient in a hospital during the last two years? ______________

4. Are you allergic to penicillin, aspirin/ASA, codeine, or any other drugs or medications? Yes / No
   If yes, please list:______________________________

5. Have you ever had any excessive bleeding requiring special treatment? ______________

6. Check any of the following, which you have now at present, or have ever had in the past:

- O Heart Failure or Disease
- O Heart Attack
- O Angina Pectoris
- O High Blood Pressure
- O Heart Murmur
- O Rheumatic Fever
- O Congenital Heart Defects
- O Artificial Heart Valve
- O Heart Pacemaker
- O Heart Surgery
- O Artificial Joint
- O Anemia
- O Stroke
- O Brain Injury
- O Kidney Trouble
- O Hemo or Parenteral Dialysis
- O Ulcers
- O Headaches or Migraines
- O Dementia
- O Wheelchair User
- O Emphysema or COPD
- O Lung or Breathing Problems
- O Tobacco Use
- O Tuberculosis
- O Asthma
- O Organ Transplant
- O Sinus Problems
- O Allergies or Hives
- O Diabetes I / II
- O Thyroid Disease
- O Cancer, Leukemia, Myeloma
- O Radiation or Cobalt Treatment
- O Chemotherapy
- O Rheumatoid or Osteo Arthritis
- O Rheumatism
- O Cortisone / Steroid Medicine
- O Glaucoma
- O Pain in Jaw Joints
- O HIV
- O Hepatitis A / B / C
- O Liver Disease
- O Yellow Jaundice
- O Blood Transfusion
- O Drug Addiction
- O Alcohol Abuse / Alcoholic
- O Hemophilia
- O Venereal Disease
- O Cold Sores
- O Epilepsy or Seizures
- O Fainting or Dizzy Spells
- O Nervousness / Anxiety
- O Psychiatric Treatment
- O Sickle Cell Trait / Disease
- O Bruise Easily
- O Snoring / Sleep Apnea
- O Injury to Face or Mouth

7. Please list any disease(s), condition(s), or problem(s) not already listed. ______________________________

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8. Have you **ever** taken bisphosphonate medications, including: Actonel (risedronate), Boniva (ibandronate), Fosamax (alendronate), or Aredia (pamidronate)? ______________________________

9. Are you currently pregnant or breastfeeding? Yes / No / Not applicable.

10. Please list all your current medications or provide a list if available. ______________________________

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Dental History

Yes	No	
O	O	Do you have tooth, gum, or head and neck pain or discomfort?
O	O	Do you feel nervous about dental treatment?
O	O	Do you notice popping, clicking, or soreness of the jaw?
O	O	Are you involved in any contact sports? (i.e., hockey, boxing, etc.)
O	O	Do you have a dry mouth?
O	O	Do you have problems with dental freezing/numbing?
O	O	Are you happy with the appearance of your teeth/smile?

When was your last dental visit? ______________

Were dental x-rays taken? Yes / No

When was your last dental cleaning? ______________

Who was your last dentist? ______________

In Office:

Dentist Review: ______________________ Date: ______________________

Dentist Notes: ______________________________