CLAREVIEW & BELMONT
DENTAL ASSOCIATES

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CANCELLATION POLICY

WE understand that with everyone's increasingly busy lives, conflicts with your scheduled appointment times can and will occur.

IN order to provide **YOU**, our patients, with prompt patient care and attention, we must ask that you provide our office with at least 48 hours' notice prior to your appointment should you need to reschedule.

PLEASE arrive on time for your appointment. If you arrive later than 15 minutes after your appointment time, we may not be able to see you that day or complete your full treatment. We will make every effort to accommodate you, however in some cases your appointment may have to be rescheduled.

IMPORTANT If you fail to provide us with the required 48 hour cancellation notice, there will be a cancellation fee of $50 per hour of your appointment time charged to you.

PERSONAL INFORMATION

Name _____ Gender M / F Date of Birth _____ /_____ /_____
(Last) (First) Please Circle Month Day Year

Address _____ Postal Code _____

Employer _____ Occupation _____ SIN _____

Marital Status _____ Spouse Name _____ Alberta Health Care_____

Phone H _____ W _____ C _____ Email _____

Can we contact & confirm your appointments by Email □ Yes □ No Text Message □ Yes □ No

Best way to contact you is 1st _____ 2nd _____ 3rd _____

How did you hear about our office or did somebody refer you? _____

Emergency Contact Name & Number _____

Dental Insurance

Primary Insurance Name _____

Group/Policy # _____

I.D/Certificate # _____

Plan holder name _____

Plan holder D.O.B _____

Plan holder relation to patient _____

Secondary Insurance Name _____

Group/Policy # _____

I.D/Certificate # _____

Plan holder name _____

Plan holder D.O.B _____

Plan holder relation to patient _____

Patient Consent:

I _____ hereby give permission to Clareview & Belmont Dental Associates and staff to perform dental treatment on myself / child / other (please state)_____. I would be responsible for the payment of my account. I have read and understood the cancellation policy as stated above. I authorize the release, to my dental benefits plan administrator and CDA, of information contained in claims submitted electronically/ manually. I also authorize the communication of information related to the coverage of services described, to Clareview & Belmont Dental Associates. I hereby assign my benefits, payable from claims submitted electronically to Clareview & Belmont Dental Associates and authorize payment directly to them.

Patient / Parent / Guardian's Signature _____ **Date** _____

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MEDICAL HISTORY

Patients Name _____ Age _____

Name of Physician and their specialty _____ Most recent physical examination _____

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

PLEASE CHECK IF YOU HAVE or EVER HAD: **Y / N**

1. Hospitalization for illness or injury _____ ❒ ❒
2. An allergic reaction to
   - ❒ Aspirin, ibuprofen, acetaminophen, codeine
   - ❒ Penicillin
   - ❒ Erythromycin
   - ❒ Tetracycline
   - ❒ Sulfa
   - ❒ Local anesthetic
   - ❒ Fluoride
   - ❒ Metals (nickel, gold, silver _____)
   - ❒ Latex
   - ❒ 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 implant (joint replacement) _____ ❒ ❒
8. Rheumatic or scarlet fever _____ ❒ ❒
9. High or low blood pressure _____ ❒ ❒
10. A stroke (taking blood thinners) _____ ❒ ❒
11. Anemia or other blood disorder _____ ❒ ❒
12. Prolonged bleeding due to a slight cut (INR>3.5) _____ ❒ ❒
13. Emphysema, shortness of breath, sarcoidosis _____ ❒ ❒
14. Tuberculosis, measles, chicken pox _____ ❒ ❒
15. Asthma _____ ❒ ❒
16. Breathing or sleep problems (sleep apnea, snoring, sinus) _____ ❒ ❒
17. Kidney disease _____ ❒ ❒
18. Liver disease _____ ❒ ❒
19. Jaundice _____ ❒ ❒
20. Thyroid, parathyroid disease, or calcium deficiency _____ ❒ ❒
21. Hormone deficiency _____ ❒ ❒
22. High cholesterol or taking statin drugs _____ ❒ ❒
23. Diabetes (HbA1c=_____) _____ ❒ ❒
24. Stomach or duodenal ulcer _____ ❒ ❒
25. Digestive disorders (celiac disease, gastric reflux) _____ ❒ ❒
26. Osteoporosis/osteopenia (i.e. taking bisphosphonates) _____ ❒ ❒
27. Arthritis _____ ❒ ❒
28. Autoimmune disease (rheumatoid arthritis, lupus, scleroderma) _____ ❒ ❒
29. Glaucoma _____ ❒ ❒
30. Contact lenses _____ ❒ ❒
31. Head or neck injuries _____ ❒ ❒
32. Epilepsy, convulsions (seizures) _____ ❒ ❒
33. Neurologic disorders (ADD/ADHD, prion disease) _____ ❒ ❒
34. Viral infections and cold sores _____ ❒ ❒
35. Any lumps or swelling in the mouth _____ ❒ ❒
36. Hives, skin rash, hay fever _____ ❒ ❒
37. STI/STD/HPV _____ ❒ ❒
38. Hepatitis (type_____) _____ ❒ ❒
39. HIV/AIDS _____ ❒ ❒
40. Tumor, abnormal growth _____ ❒ ❒
41. Radiation therapy _____ ❒ ❒
42. Chemotherapy, immunosuppressive medication _____ ❒ ❒
43. Emotional difficulties _____ ❒ ❒
44. Psychiatric treatment _____ ❒ ❒
45. Antidepressant medication _____ ❒ ❒
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 (fever, chills, new cough, diarrhea) _____ ❒ ❒
49. Taking medication for weight management _____ ❒ ❒
50. Taking dietary supplements _____ ❒ ❒
51. Often exhausted or fatigued _____ ❒ ❒
52. Experiencing frequent headaches _____ ❒ ❒
53. A smoker, smoked previously or use smokeless tobacco ___ ❒ ❒
54. Considered a touchy/sensitive person _____ ❒ ❒
55. Often unhappy or depressed _____ ❒ ❒
56. Taking birth control pills _____ ❒ ❒
57. Currently pregnant _____ ❒ ❒
58. Prostate disorders _____ ❒ ❒

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (botox, collagen injections etc.)

_____

_____

List all medications (its purpose), supplements, and or vitamins taken within the last two years

_____

_____

_____

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

Patient / Parent / Guardian's Signature _____ **Date** _____

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DENTAL HISTORY

Patients Name _____ Age _____

How would you rate the condition of your mouth? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Previous Dentist _____ How long have you been a patient? _____

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 months ❒ 4 months ❒ 6 months ❒ 12 months ❒ Not routinely

What is your immediate concern? _____

_____

PERSONAL HISTORY	**Y / N**
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?	❒ ❒
6. Have you had any teeth removed or missing teeth that never developed?	❒ ❒
GUM AND BONE	
7. Do your gums bleed or are they 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 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?	❒ ❒
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 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 bite your teeth together?	❒ ❒
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	❒ ❒
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	❒ ❒
25. Are your teeth becoming more crooked, crowded, or overlapped?	❒ ❒
26. Are your teeth developing spaces or becoming more loose?	❒ ❒
27. Do you have more than one bite, squeeze, or shift you 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 your teeth in the daytime or make them sore?	❒ ❒
31. Do you have any problems with sleep (i.e. restlessness); wake up with a headache or an awareness of your teeth?	❒ ❒
32. Do you wear or have you ever worn a bite appliance?	❒ ❒
SMILE CHARACTERISTCS	
33. Is there anything about the appearance of your teeth that you would like to change?	❒ ❒
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 / Parent / Guardian's Signature _____ **Date** _____