CLAREVIEW & BELMONT
DENTAL ASSOCIATES

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

Address: _____ City: _____ Postal Code: _____/_____

Marital Status _____ Spouse Name _____ Employer_____ Occupation_____ SIN _____

Phone: H: _____W: _____ C: _____ Email: _____

Can we contact you by: Email □ Yes □ No Text Message □ Yes □ No Best way to contact you is 1st _____ 2nd _____ 3rd _____

Referred by:_____ Emergency Contact & P#: _____

Medical Doctor: _____P#:_____Last check up date: _____ Alberta Health Care #:_____

Are you taking any medications regularly? (include vitamins, aspirins etc.) _____

_____

Have you ever had a serious illness or are you under the care of a physician now? _____

Do you have any of the following medical conditions?

	Y / N		Y / N		Y / N
Rheumatic Fever	□ □	HIV Positive	□ □	Arthritis	□ □
Heart Murmur	□ □	Hepatitis A / B / C	□ □	Artificial Joint Hip / knee	□ □
Pacemaker	□ □	Exposure to HIV	□ □	Seizures / Epilepsy	□ □
Artificial Heart Valve	□ □	Tuberculosis	□ □	Psychological Disorder	□ □
Stroke	□ □	Asthma / Hay Fever	□ □	Nervous Disorder	□ □
High / Low Blood Pressure	□ □	Persistent Cough/ Lung Conditions	□ □	Alcohol Dependency	□ □
Other Heart Problems _____		Shortness of Breath	□ □	Cancer	□ □
Blood Disorder	□ □	Fainting	□ □	Radiation Therapy / Chemotherapy	□ □
Prolong Bleeding/Bruise Easily	□ □	Tobacco Products	□ □	Any Contagious Disease	□ □
Swollen ankles	□ □	Thyroid Conditions	□ □	MEDICAL ALERTS _____	
Anemia	□ □	Diabetes	□ □	Premedication_____	
Kidney problems	□ □	Gastrointestinal Disease	□ □	Woman only: Are you pregnant or suspect that	
Jaundice	□ □	Ulcer	□ □	you might be? Y / N Delivery Date _____	

Allergies: Do you have unusual reactions to any of the following materials or drugs? If so, what kind of reactions?

Food _____ Chemicals _____ Others _____

□ Penicillin □ Sulfa drug □ Erythromycin □ Codeine □ Tylenol □ Aspirin □ Motrin □ Dental local anesthesia (freezing) □ Xylocaine □ Ultracaine
□Epinephrine □Metal □Latex □Others _____

Dental History: When was your last dental check up: _____ Any dental xrays within the past year:_____

Do you have the following problems?

	Y / N		Y / N		Y / N
Bleeding Gums/Sensitive Teeth……..	□ □	Ear Ringing / Pressure	□ □	Food Catches between Teeth	□ □
Injury / Surgery to Face or Jaws……	□ □	Grinding / Clenching	□ □	Jaw Pain	□ □
Frequent / Morning Headaches	□ □	Bad Breath	□ □	Tooth Brushing Instructions……..	□ □
Are you nervous about your appointment....	□ □	Loose Teeth	□ □	Dental Flossing Instructions ……..	□ □
		Object to Xrays ……	□ □	Do you object to dental fluoride ……..	□ □

Are you unhappy about your appearance of your teeth/smile? _____

What is your present concern about your teeth? _____

Dental Insurance 1st – Plan Holder: _____ Ins Co: _____ Policy/Group _____ ID: _____
2nd – Plan Holder: _____ Ins Co: _____ Policy/Group _____ ID: _____

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.

Patient / Parent / Guardian's Signature _____ Date _____

I authorize 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 herby assign my benefits, payable from claims submitted electronically to Clareview & Belmont Dental Associates and authorize payment directly to him/ her.

Patient / Parent / Guardian Signature_____ Date _____

CLAREVIEW & BELMONT
DENTAL ASSOCIATES

2911 – 137 Avenue Edmonton, AB T5A 5G8 P: 780-475-5922 F: 780-475-8998 E: info@cbdental.ca

Cancellation Policy

We understand that with everyone's increasingly busy lives, conflicts with your scheduled appointment times can and will occur. In some cases, despite your best efforts, you will not be able to attend your appointment on the given date, or at the given time.

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.

This will allow us to effectively utilize that appointment time slot for another patient who has also been waiting for an appointment.

We will write down your appointment time clearly on an appointment card so you remember to attend, but it is ultimately your responsibility to keep this appointment or reschedule in a timely manner.

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 $50.00 per hour of your appointment time charged to you.

These fees are necessary to cover the administration costs of cancellations and rescheduling and to cover the staffing and equipment costs associated with your appointment.

Patient Name_____
Please Print

Patient (or Guardian) Signature_____ Date_____

Witness Signature_____ Date_____