RUNDLE DENTAL
Your Smile. Our Focus.

3B-3735 Rundlehorn Dr NE
Calgary, AB T1Y 2K1

(587) 317-9903

PATIENT INFORMATION (Confidential)

First Name _____Last Name_____Birth date _____

Address _____ City _____ Prov _____ Postal Code _____

Home Phone _____ Work Phone _____ Cell Phone_____

Employer_____Marital Status_____

E-mail _____Gender_____

Emergency Contact/Parent Contact_____ Phone # _____

1. Relationship to patient:_____

2. Is there anyone else in your household that is a patient here?_____

   If yes please list_____

3. Are you a student (University /College student)?_____

   If yes please name school:_____

WOMEN ONLY:

4. Are you pregnant?_____

   If Yes when is the due date?_____

5. What is your primary reason for booking the appointment today?_____

6. How would you prefer your appointment reminders? ☐ Email ☐ Phone ☐ Call ☐ Text

7. How did you hear about us? ☐ Family/Friend ☐ Website ☐ Internet/Google ☐ Facebook ☐ Other
   If you selected Family/Friend or other, whom shall we thank for your referral?_____

8. Would you like to be direct billed? ☐ Yes ☐ No

9. Do you want dental insurance? ☐ Yes ☐ No

PRIMARY INSURANCE POLICY

Insurance Company _____ Policy #_____

Sub ID #_____

Policyholder's Name _____

Policyholder's Date of Birth _____

Place of Employment_____ Work Phone _____

SECONDARY INSURANCE POLICY

Insurance Company _____ Policy #_____

Sub ID #_____

Policyholder's Name _____

Policyholder's Date of Birth _____

Place of Employment_____ Work Phone _____

CREDIT CARD AUTHORIZATION

Our office will gladly direct bill your insurance company on your behalf. In order to direct bill your insurance company, we kindly ask that you leave an imprint of your credit card and any amounts not covered by your insurance company will be charged to your credit card and an email receipt sent. Please advise us of any future changes in your credit card.

I authorize Rundle Dental to process invoice charges to my:

☐ Visa ☐ Mastercard

Credit Card #:_____

Expiry Date:_____

Patient(s) on Account:_____

Name(s) of Patient That The Credit Card is Authorized For:_____

Cardholder First Name:_____ Cardholder Last Name_____

Cardholder E-mail Address:_____

CardholderSignature:_____

Date:_____

The balance remaining after we have received your insurance benefits, will be charged to your credit card. This authorization will be in effect until notice of cancellation is forwarded in writing to Rundle Dental.

MEDICAL HISTORY

Physician _____ Physician's Office Phone_____

8. Date of Last Medical Exam _____

9. Are you currently under any medical treatment? ☐ Yes ☐ No

10. Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☑ No

11. Are you currently taking any medications, including over the counter medications?_____

Please list:_____

12. Do you have or have had any of the following? Please check all that apply.

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug/Alcohol Dependency
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Headaches/Migraines
- ☐ Head/Neck/Jaw Injuries
- ☐ Heart Disease/Angina
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Tumors
- ☐ Venereal Disease
- ☐ Smoker
- ☐ Osteoporosis Medications
- ☐ None of These

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

MEDICAL HISTORY

13. Are there any conditions or diseases not listed above that you have or ever had? ☐ ☐
    If yes, please explain:_____
14. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, or heart disease) If yes, please explain: _____ ☐ ☐
15. Do you have a history of snoring/sleep apnea?_____ ☐ ☐
    If so do you use a CPAP machine? _____ ☐ ☐
16. Do you often find it difficult to breathe through your nose?_____ ☐ ☐
17. Do you have any allergies to medications? _____ ☐ ☐
    If yes please list:_____

DENTAL HISTORY

18. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____ ☐ ☐
19. Have you had an unfavorable dental experience or complications following dental treatment?____ ☐ ☐
20. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ ☐ ☐
21. Did you ever have braces, or orthodontic treatment. _____ ☐ ☐

Check All That Apply *

- ☐ Gums bleed while you brush
- ☐ Your teeth are sensitive to hot or cold liquid/foods
- ☐ You feel pain in any of your teeth
- ☐ Have any sores/lumps in your mouth
- ☐ You bite your lips or cheeks frequently
- ☐ Had any difficult extractions or prolonged bleeding from it in the past
- ☐ You wear dentures or partials
- ☐ none

BITE AND JAW JOINT

22. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
23. Do you have any problems with sleep (i.e. restlessness), or wake up with a headache or an awareness of your teeth?_____ ☐ ☐
24. Do you wear or have you ever worn a bite appliance or nightguard?_____ ☐ ☐
25. Do you feel that you clench or grind your teeth?_____ ☐ ☐

SMILE CHARACTERISTICS

26. Is there anything about the appearance of your teeth or smile that you would like to change, or felt uncomfortable/self conscious about?_____ ☐ ☐
27. Have you ever whitened (bleached) your teeth?_____ ☐ ☐

CONSENT FOR SERVICES

I, the undersigned, also certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary to obtain information that is required for my dental care.

I agree to pay value of said services which shall be as billed, unless objected to by me, in writing, within the time for payment thereof. I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand my personal information disclosed is protected by the Privacy Act. I agree that Rundle Dental can electronically file dental claims on my behalf.

I have read the above conditions of treatment and payment and agree to their content.

Signature_____ Date_____