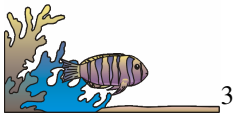

CORAL SPRINGS DENTAL CENTRE

31 Coral Springs Blvd NE Calgary, Alberta T3J 4J1 Tel (403)568-0456 Fax (403)568-0411

PATIENT INFORMATION (Please fill out these forms carefully)

Name: Dr. Mr. Mrs. Ms. Miss. _____

Parent/ Guardian (if child is a minor): _____

Address: _____ Postal Code: _____

Home Phone: _____ Work Phone:_____ Cell Phone: _____

Birth date: _____ Occupation: _____

Employer/School: _____

How did you hear about our office? _____

MEDICAL HISTORY

Please Circle

Physician's Name _____ Phone No: _____

Approximate date of last physical exam _____Were there any concerns? _____

Are currently taking any medications Y N

If so what are the medications and what are they used for?_____

_____

Do you have any allergies (ie. Penicillin, Codeine, Aspirin, Latex)? Y N

If so, to what? _____

Do you have a Heart murmur? Y N

Have you ever needed to take antibiotics BEFORE a dental appointment because of a heart murmur? Y N

Have you ever had problems with excessive bleeding? Y N

List any major medical conditions you have (ie. Heart condition, Lung disease, Hepatitis, Aids, HIV +, High or Low Blood pressure, Diabetes, Cancer)_____

_____

Do you smoke? Y N

Women Only: Are you pregnant? Y N

DENTAL HISTORY

What is your Dental concern at this time? _____

Are you in any pain right now? Y N

When was your last dental visit? _____ Were any x-rays taken? _____

Who was the Dentist? _____ What was done at that visit? _____

Are you happy with the appearance of your teeth? Y N

If not, what would you like to change? _____

Have you ever had pain in or around your jaw joints? Y N

Have you had your wisdom teeth removed? Y N

Have you had problems in the past with Dental freezing? Y N

If so, what was the problem? (ie. a bad reaction, difficult to freeze) _____

_____

CORAL SPRINGS DENTAL CENTRE

31 Coral Springs Blvd NE Calgary, Alberta T3J 4J1 Tel (403)568-0456 Fax (403)568-0411

INSURANCE INFORMATION (if applicable)

FIRST INSURANCE: (Must be valid)

Policy Holder _____

Policy Holder's Birth date _____

Employer of Policy Holder _____

Insurance Company _____

Policy/Plan # _____

Certificate or ID # _____

SECOND INSURANCE: (Must be valid)

Policy Holder _____

Policy Holder's Birth date _____

Employer of Policy Holder _____

Insurance Company _____

Policy/Plan # _____

Certificate or ID # _____

IMPORTANT AND MUST BE FILLED OUT

FINANCIAL AGREEMENT:

Except in the case of an emergency or at the discretion of this Office, I will be charged :

$25 for appointments cancelled with less than 48 hours notice.

$50 for "No-show" appointments or appointments cancelled the same day.

I will be permitted to assign Insurance benefits ***only if***:

- I leave a valid credit card on file to be charged with the remaining balance if any, after payment has been received from the Insurance Company.

  Visa / MC/ Amex _____ Expiry Date _____

Or

- I will pay 20% of the treatment provided by the dentist **at the time of service**, if no response is received electronically from the Insurance Company indicating otherwise, or I have no proof of % coverage. Any credits will be reimbursed to me.

  I will pay by Amex ___ Visa ___ M/C ___ Debit Card ___ Cash ___

Signature: _____ Date: _____

CONSENT

I, the undersigned, understand that the information contained in the dental and medical history portions of my chart/ and those of my dependents, is important to my/our treatment. I certify that all the information I have given is correct. I consent to the release of medical information from my medical doctor or other health professionals as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment **for both me and my dependents.** I assume all responsibility for fees associated with these dental procedures.

Signature: _____ Date: _____