ALLIANCE
ENDODONTICS

#205, 60 Green Grove Drive, St. Albert, AB T8N 5H6
Phone: 780-569-0255 Fax: 780-569-0297
Email: drbrown@allianceendodontics.ca

Welcome to our office. Please answer the following questions to the best of your ability. All information will be kept confidential, as per the Health Information Act of Alberta.

PATIENT INFORMATION

First Name _____ Last Name _____ Preferred Name _____

Address _____

City _____ Province _____ Postal Code _____

Home # _____ Business # _____ Cell # _____

Email Address _____

Date of Birth (DD/MM/YY) _____ Occupation _____

Dentist _____ Family Doctor _____

Emergency Contact _____ Relationship _____ Phone # _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company Name _____

Policy/Plan/Group # _____ Certificate/ID # _____

Policy Holder's Name _____ Date of Birth (DD/MM/YY) _____

Secondary Insurance Company Name _____

Policy/Plan/Group # _____ Certificate/ID # _____

Policy Holder's Name _____ Date of Birth (DD/MM/YY) _____

PARENT/GUARDIAN INFORMATION (if patient is under 18)

First Name _____ Last Name _____

Relationship to Patient _____

Address (if different from above) _____

City _____ Province _____ Postal Code _____

Home # _____ Business # _____ Cell # _____

PATIENT HEALTH HISTORY

Name _____ Date of Birth (DD/MM/YY) _____

1.) Has there been any change in your health within the last year? _____ ☐ Yes ☐ No

If yes, please explain: _____

2.) Are you currently under a physician's care for a specific reason? _____ ☐ Yes ☐ No

If yes, please explain: _____

3.) Have you had any serious illness or hospitalizations? _____ ☐ Yes ☐ No

If yes, please explain: _____

4.) Please list all operations and dates: _____

_____

5.) Do you have or have you ever had any of the following:

Heart murmur or heart valve defect	Y	N	Fainting spells, seizures, epilepsy, dizziness	Y	N
Rheumatic fever or rheumatic heart disease	Y	N	Liver disease (jaundice, hepatitis)	Y	N
Heart valve replacement	Y	N	Kidney disease	Y	N
Cardiovascular disease (please circle): Chest pain, heart attack, heart trouble, coronary artery disease, high blood pressure, low blood pressure, stroke, palpations, heart surgery, angioplasty, pacemaker, shortness of breath, swollen ankles or hands	Y	N	Lung disease (please circle): asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough	Y	N
Blood disorder (please circle): bleeding disorder, anemia, bruise easily, sickle cell disease	Y	N	Jaw/TMJ problems (please circle): clicking, pain in the joint, ear, side of face, difficulty opening/closing your mouth or chewing	Y	N
Diabetes (type 1 or 2)	Y	N	Thyroid disease	Y	N
Arthritis or inflammatory rheumatism	Y	N	Stomach ulcers or intestinal problems	Y	N
Glaucoma	Y	N	Hay fever, skin rash, hives, sinus trouble	Y	N
Hypoglycemia or low blood sugar	Y	N	Osteoporosis	Y	N
Cancer	Y	N	Artificial joints (hip, knee, etc.)	Y	N
Radiation (head/neck area)	Y	N	Psychiatric disorders	Y	N
HIV or hepatitis A, B, C	Y	N	Sleep apnea	Y	N
Recurrent infection of any kind	Y	N	Brain injury/concussion	Y	N

Please list any other medical conditions not covered above: _____

_____

6.) Are you currently taking any medications? _____ ☐ Yes ☐ No

If yes, please list all medications:

Medication: _____ Medication: _____

Medication: _____ Medication: _____

Medication: _____ Medication: _____

Medication: _____ Medication: _____

7.) Are you allergic or have you had a bad reaction to any of the following (please circle):

Local anesthetic	Aspirin, Ibuprofen, NSAIDS	Latex
Sulfa drugs	Penicillin or other Antibiotics	Barbiturates or sleeping pills
Codeine or other narcotics	Steroids	Soy or egg products

Do you have any other allergies or reactions not listed above? □ Yes □ No Please explain: _____

_____

8.) Do you smoke? □ Yes □ No Quantity? _____ Do you drink? □ Yes □ No Quantity? _____

9.) Do you use any recreational or illicit drugs? □ Yes □ No Please describe: _____

WOMEN ONLY

Are you pregnant, trying to get pregnant, or might be pregnant? _____ □ Yes □ No

Are you breastfeeding? _____ □ Yes □ No

Are you taking hormonal replacement? _____ □ Yes □ No

Are you taking oral birth control? _____ □ Yes □ No

If you are using oral contraceptives, it is important that you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, during and after the course of the antibiotics or other medication is completed. Please consult your physician for further guidance. I have read and understand the above. _____ Please Initial

PATIENT CONSENT AND PRIVACY AGREEMENT

I, the undersigned, certify that I have provided accurate and complete personal, medical and dental history information and have not knowingly omitted any information.

I, the undersigned, authorize the release of information contained in claims or pre-authorizations submitted electronically or manually to my dental benefits plan administrator. I also authorize the communication of information related to the coverage of services described to the dentist.

Protecting your personal information is an important part of our office. We are committed to collecting, using and disclosing your personal information responsibly. Alliance Endodontics will collect, use and disclose information about you for the following purposes:

- to offer and provide treatment, care and services in relation to your dental care
- to communicate with other treating health care providers, including your referring dentist, specialists, other general dentists and physicians, as required
- to allow us to maintain communication and contact with you via phone or email (i.e. book and confirm appointments, follow up for treatment, care calls, insurance claims or pre-authorizations)

I, the undersigned, have reviewed the above information and consent to the collection, use, retention and disclosure of my personal information provided, as is required for my own or my dependent's dental care.

Patient Name (printed): _____ Date: _____

Signature: _____ Relationship to Patient: □ Self □ Parent/Guardian