NEW PATIENT INFORMATION & HEALTH HISTORY FORM

Please complete this form and email to reception@strembiskidental.com or fax to 403 342-4403

Title:	Given Name:	Last Name:	
Address:		City:	Postal Code:
Date of Birth: (m/d/y)	Gender:	Cell Phone:	Other Phone:
Email Address:		How did you choose us?	

DENTAL INFORMATION

Please circle Yes (Y) or No (N) to the following questions

Do your gums bleed when brushing/flossing?	Y	N	Do you bite your lips or cheeks frequently?	Y	N
Have you had orthodontic treatment (braces)?	Y	N	Do you suffer from headaches or migraines?	Y	N
Are your teeth sensitive to cold, heat, sweets?	Y	N	Have you had difficult extractions in the past?	Y	N
Do you have tooth pain/ache?	Y	N	Do you wear an appliance, nightguard etc.?	Y	N
Do you frequent sores in or around your mouth?	Y	N	Do you have difficulty opening/closing your jaw?	Y	N
Have you ever had a head, neck or jaw injury?	Y	N	Have you had periodontal treatment (gums)?	Y	N
Do you have any loose teeth?	Y	N	Does food frequently get caught in your teeth?	Y	N
Are you nervous about dental treatment?	Y	N	Are you happy with the appearance of your teeth?	Y	N

Please describe any dental concerns you may have:

Date of last dental exam/cleaning (m/d/y): Date of last x-rays taken (m/d/y):

MEDICAL INFORMATION

All information is strictly confidential in accordance with applicable laws. Please answer the following:

Name & location of family doctor:	Have you been hospitalized in the past 2 years? Please explain:
Women: Are you pregnant? Y N	If yes, expected delivery date:

Please circle Y or N if you've had or currently have the following:

AIDS/ HIV Positive	Y	N	Chest Pain	Y	N	Alzheimer's Disease	Y	N
Anemia	Y	N	Diabetes	Y	N	Artificial Heart Valve	Y	N
Asthma	Y	N	Hepatitis A	Y	N	High Blood Pressure	Y	N
Cancer	Y	N	Hepatitis B or C	Y	N	Sickle Cell Disease	Y	N
Chemotherapy	Y	N	Glaucoma	Y	N	Mental/Nervous Disorder	Y	N
Heart Murmur	Y	N	Hemophilia	Y	N	Organ/Medical Transplant	Y	N
Heart Attack/Failure	Y	N	Tuberculosis	Y	N	Head or Neck Injuries	Y	N
Pace Maker	Y	N	Stroke	Y	N	Circulation Problems	Y	N
Heart Surgery	Y	N	Emphysema	Y	N	Anaphylaxis	Y	N
Lung Disease	Y	N	Liver Disease	Y	N	Arthritis / Gout	Y	N
Blood Disease	Y	N	Bruise Easily	Y	N	Artificial Joint	Y	N
Fainting	Y	N	Kidney Problems	Y	N	Epilepsy / Seizures	Y	N

Please add any additional medical information we need to be aware of:

Please list any prescription or non-prescription medicine you are currently taking or have taken recently:

Are you allergic or have had a reaction to the following:			Please list any allergic reactions below. Including hay fever, metal and latex allergies, food allergies etc.		
Antibiotics	Y	N			
Aspirin	Y	N			
Codeine	Y	N			
Local Anaesthetic	Y	N	Does it take a long time to stop bleeding?	Y	N
Nitrous Oxide	Y	N	Do you get frequent ear or throat infections?	Y	N
Other:			Do you suffer from sinus infections?	Y	N
			Do you wear glasses or contact lenses?	Y	N

Do you use tobacco products or wear a nicotine patch?	Y	N	Are you dependant on alcohol or drugs?	Y	N

CHILDREN ONLY

Please list any medical conditions or illnesses your child has recently had. This includes Measles, Strep Throat, Tonsillitis, Chicken Pox etc.

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
Subscriber Name:		Subscriber Name:	
Date of Birth (m/d/y):	Relationship:	Date of Birth (m/d/y):	Relationship:
Employer:	Insurance Company:	Employer:	Insurance Company:
Policy Number #	Division Number #	Policy Number #	Division Number #
Subscriber ID #		Subscriber ID #	

We accept direct payment from your dental plan, should your plan allow for assignment of benefits, for the cost of those dental services which we may provide and which your plan covers.

Dental plans are too numerous and varied to allow us to know the exact details of all of them. Your dental plan may not cover the full extent of the costs you incur for dental treatment. There may also be procedures that are not covered by your plan, these factors are beyond our control.

Please review your dental plan very carefully to ensure you understand the exclusions and limitations of your plan. If your dental plan does not cover the full cost of treatment, you will be responsible for any difference between the amount paid by your plan and the amount charged for treatment.

I certify that I have read or have read to me the contents of this form. I have answered all questions completely and accurately to the best of my knowledge.

Patient / Guardian Signature	**Date**