Prairie Mall Dental Clinic

Name: ______________________ Date: ______________________

Address: ______________________ Apt. No. ______ City: ______________________

Postal Code: ____________ H#. ______________ Bus/Cell. ______________

Age ___ Weight ______ Sex _____ School: ____________ Date of Birth: ___________

Employer: ____________________ E-MAIL : ______________________________.

Identification: Drivers Lic. No. ____________________ S.I.N. ____________________

AHC # ______________________ Name of Physician ______________________

How did you hear about our office?

____

METHOD OF PAYMENT

Name of Dental Insurance ________________ Policy No. ____________________

Debit Card No: ________________________ Cash: ________________________

Main Credit Card Type: ____________ Name on Credit Card: ________________

Credit Card No. ______________________ Credit Card Expiry Date: ___________

Confidential Medical History – Please check the appropriate square

	yes	no
Are you presently under the care of a physician?		
Is your health good?		
Are you taking any medication or drugs?		
If so, which ones		
Have you been warned against taking any medications or chemicals?		
If so, which ones?		
Have you an allergy, hay fever or asthma?		
If so, which ones?		
Have you ever experienced any unusual reaction to local or general anaesthesia?		
Do you bruise easily or have prolonged bleeding?		
Do you have any disorders?		
Have there been any recent changes in weight, thirst or appetite?		
Have you ever had any injury, surgery or radiation therapy to your head, face or jaws?		
Have you ever had any major surgery?		
Are you pregnant at this time?		

Please continue on page 2/2

If you have ever had or been treated for any of the following, please circle

Rheumatic fever, hepatitis, scarlet fever, diphtheria, tuberculosis or lung disease, diabetes, heart attack or heart disease, stroke, epilepsy, gall bladder disease, liver or kidney, disease, high blood pressure, cancer, aids.

I consent to whatever dental procedures, anaesthetic and/or x-rays that are necessary for the treatment of my case

I consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependents dental care.

Patient's Signature: ______________________________

ANY PORTION YOUR INSURANCE DOES NOT COVER YOU WILL BE RESPONSIBLE FOR.
Do you prefer white / silver fillings on your back molars? Please Circle.

Chief Complaint: ______________________________

____

MAIN COMPLAINT:

INITIAL RADIOGRAPHY EXAM

PAN ____ BW ____ FMX ____ PA ____

Bone Loss ____

Furcations ____

Apical Lesions ____

Im_ tions ____

Remarks ____

INITIAL PERIODONTAL EXAM

Inflammation	Mild☐	Moderate☐	Severe☐
Plaque	Mild☐	Moderate☐	Severe☐

Food Impaction ____

Calculus Mild☐ Moderate☐ Heavy☐

Supra☐ Subgingival☐

PSR

Staining Mild☐ Moderate☐ Heavy☐

Halitosis ____

Oral Hygiene	Poor☐	Fair☐	Good☐	Excellent☐
Flossing	Yes☐	No☐		
Smoking	Yes☐	No☐		
Attached Gingiva	Pink☐	Red☐	Blue☐	
	Firm☐	Swollen☐	Receded☐	

Attachment Loss ____

DIAGNOSIS

Gingivitis	Early☐	Moderate☐	Advanced☐
Periodontitis	Early☐	Moderate☐	Advanced☐
		Localized☐	Generalized☐

Remarks

INITIAL OCCLUSION

Molar Relation Left ____ Right ____

Cuspid Relation Left ____ Right ____

Overjet ____ Overbite ____ %

Crossbite ____

Habits: Thumb☐ Tongue☐ Mentalis☐

Remarks ____

INITIAL TMJ

Pain	No☐	Left☐	Right☐
Popping	No☐	Left☐	Right☐
Crepitus	No☐	Left☐	Right☐

Maximum Opening ____ mm

Deviation on Closing ____ Rmm ____ Lmm

INITIAL SOFT TISSUE EXAM

Tonsils ____

Palate ____

Tongue ____

Throat ____

Floor ____

Lymph Nodes ____

Buccal Mucosa ____

Buccal Vestibule ____

R L

Attached Gingiva ____

Remarks ____

NEW PATIENT TEMPLATE

PRIVACY, DISCLOSURE, & CONSENT

Information for our Patients

At Prairie Mall Dental Clinic, all professional dental services are performed by licensed members of the Alberta Dental Association and College ("Dental Professionals"), and all institutional health care related services are performed independently by Prairie Mall Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Prairie Mall Dental Clinic and Prairie Mall Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Prairie Mall Health Services.

Privacy Act and Consent to Treatment

By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Prairie Mall Dental Clinic; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Prairie Mall Dental Clinic to provide the services you are requesting.

Acknowledgement regarding Information Provided

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical – dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among Prairie Mall Dental Clinic, Prairie Mall Health Services, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Prairie Mall Dental Clinic and Prairie Mall Health Services in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that the Prairie Mall Dental Clinic and Prairie Mall Health Services are relying upon the information which I have provided being accurate and complete.

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Print Name of ☐Patient ☐Parent ☐ Guardian

____
Signature of ☐Patient ☐Parent ☐ Guardian

____
Date

____
Reviewed by Prairie Mall Dental Clinic

____
Date