SMILES DENTAL GROUP

110 , 4445 Calgary Trail NW, T6H5R7
Telephone: 587-410-5994 Fax: 780-989-2046
Email:terrace@smilesdentalgroup.com

Patient Information

Patient Name: _____ Sex: _____

Parent/ Guardian Name: _____

Date of Birth: _____ Home #: _____ Cell #: _____

Address: _____

City: _____ Postal Code: _____ Email: _____

HOW DID YOU HEAR ABOUT US? A) Flyer B) Google C) Website D) Family/Friend_____
E) Live Nearby F) Facebook G) Walk In H) Other_____

Insurance #1

Policy Holder _____

DOB _____

Ins Carrier _____

Group/Plan #_____

ID/Certificate #_____

Insurance #2

Policy Holder _____

DOB _____

Ins Carrier _____

Group/Plan #_____

ID/Certificate #_____

Medical History

1. Have you been under the care of a medical doctor during the past two years? **Y/N**
If YES, for what? _____
Physicians Name _____ Phone Number _____
Pharmacy Name _____ Phone Number _____
Address_____
Emergency Contact_____ Phone Number _____
Relationship _____

2. Have you taken any medication or drugs during the past two years? **Y/N**
If YES, please list _____

3. Are you taking any medications, drugs or pills right now? **Y/N**
If YES, please list name/ dosage_____

4. Are you aware of having any allergic reaction to any substance or medication? **Y/N**
If YES, please list _____

5. Have you been in the hospital in the past five years? **Y/N**
If YES, please indicate reason _____

_____ _____ _____
Date Name Signature

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Please indicate with a ✓ which of the following you've had, or have currently:

Heart Surgery/ Disease/ Attack		Asthma		Hepatitis A/B	
Chest Pain		Hay Fever		Yellow Jaundice	
Congenital Heart Disease		Latex Sensitivity		Venereal Disease	
Heart Murmur		Allergies/ Hives		AIDS	
High Blood Pressure		Ulcers		HIV Positive	
Low Blood Pressure		Diabetes		Cold Sore/ Fever Blisters	
Artificial Heart Valve		Sinus Troubles		Blood Transfusion	
Heart Pacemaker		Radiation Therapy		Hemophilia	
Rheumatic Fever		Chemotherapy		Sickle Cell Disease	
Stroke		Tumors		Bruise Easily	
Artificial Joints		Glaucoma		Neurological Disorders	
Arthritis/ Rheumatism		Emphysema		Epilepsy or Seizures	
Cortisone Medication		Liver Disease		Fainting/ Dizzy Spells	
Kidney Troubles		Tuberculosis		Psychiatric Care	
Thyroid Problems		Chronic Cough		Nervous/ Anxious	

6. Do you have, or have had any disease, condition, or problems not listed? **Y/N**
If YES, please list _____
7. WOMEN ONLY
Are you Pregnant **Y/N** Are you Nursing **Y/N** Taking Birth Control Pills **Y/N**

Consent to Photograph

I, the undersigned, give permission to Smiles Dental Group, and/or parties designated by Smiles Dental Group and/or 8 Cubed Holdings to photograph/ video me and use such photograph(s)/ video(s) in all forms of media, for any and all promotional purposes including advertising, display, audiovisual, exhibition or editorial use.

I further consent to the use of my name in connection with the photograph/ video if needed by Smiles Dental Group, and/or parties designated by Smiles Dental Group. I understand and agree that I will not receive any payment for time or expenses or any royalty for the publication of the photograph/video or the use of my name and I hereby release the Smiles Dental Group and/or parties designated by Smiles Dental Group from any such claims.

I certify that I have read and fully understand this consent and release, and that all the questions pertaining to this consent have been answered to my satisfaction

_____ _____ _____
Date Name Signature

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Office Policies Form

Welcome to Smiles Dental Group. You have many choices when it comes to choosing a dental office, and we are glad that you have chosen us to provide you and your family with the most advance dental treatments available. Everyone at our office is committed to providing quality dental care in a comfortable environment. Please take a few minutes to familiarize yourself with our office hours and policies.

1. Although many dental offices are non assignment, our office will accept direct billing of benefits from your insurance company as part of our client services. It is important for you to understand that there may be differences between our fees and what your insurance company will pay for treatment. You are responsible for any difference in fees.

2. In order to provide direct billing to our patients, we will require our patients to provide us with a credit card of file. If we cannot calculate your balance at your dental visit with certainty, you will be required to pay 25% deposit. This may result in a small balance or credit on your account. If a balance still remains upon receiving payment we will charge the remaining balance to the credit card on file and then notify you via phone.

3. Patients medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

I, _____ authorize Smiles Dental Group to keep my signature on file and to charge my credit card for balances and charges related to my dental treatment provided.

Cardholder Signature: _____ Date: _____

Periodontal Therapy/ Treatment and Maintenance Program

1. The #1 cause of tooth loss in adults is periodontal disease, which is linked to cardiovascular disease and other serious systemic diseases. Smiles Dental Group is committed to helping you manage and treat gingivitis and periodontitis, however we require a commitment from you in order to achieve overall oral health

2. In addition to proper and consistent care, you will be expected to maintain your regular scheduled periodontal therapy/ re-care appointments as recommended by your dental hygienist. These appointments will be scheduled in advance and you will receive reminders**. If you need to change this or any dental appointment our office requires two business days' notice in order to do so, failure to provide adequate notice may result in a charge of $50.00.**

3. Please acknowledge that this is a general dental practice, not a specialist practice; however we do offer certain services such as dental implants, bone grafts, IV sedation, TMJ treatment, sleep apnea, orthodontics, wisdom teeth etc

4. We require your signature below to indicate your consent to perform the dental and oral procedures deemed necessary for treatment, including the use of local anesthetic and/or relative analgesia as indicated, and that you assume responsibility for the fees associated with those procedures and finance charges if you fail to do so within adequate time

I have read and am aware of the above policies. I understand that I am responsible for the fees associated with the services I receive. Should I choose to direct bill my insurance company, I will be responsible for payment of any unpaid balance the day of service. I consent to the collection, use, and disclosure of my personal information when permitted or required by law.

_____	_____	_____
Date	Name	Signature