SMILES
DENTAL GROUP

Patient Name: _____

Patient/ Guardian: _____

Date of Birth: DD/MM/YYYY Sex: _____

Telephone: _____ Email: _____

Address: _____ City: _____

Postal Code _____ Preferred Contact: _____

Primary Dental Concerns (*Please indicate with a ✓ which of the apply to you)*

Routine checkup and cleaning		Resolving Dental Pain		Replacing Missing Teeth	
Braces / **Invisalign**		Wisdom Teeth surgery		Cosmetic Dentistry Veneers, Crowns	
Root Canals/ Endodontic Treatment		Dental Implants		Dental Bridges	
Composite Fillings		Airway and/ or TMJ		**Other:**	

How did you hear about us: A) Google B) Website C) Family/Friend named: _____ D) Live in the area

Medical History

1. **Alberta Health Card Number**_____Height_____Weight_____
2. Primary Care Doctor and Contact: _____
3. Emergency Contact_____ Phone Number _____
4. Have you taken any medication or drugs during the past two years? **Y/N**
   If YES, please list _____
5. **Are you taking any medications**, drugs or pills right now? **Y/N**
   If YES, please list name/ dosage_____
   _____
6. Are you aware of having **any allergic reaction** to any substance or medication? **Y/N**
   If YES, please list _____

_____ _____ _____
Date Name Signature

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

7. Have you been in the hospital in the past five years? **Y/N**
   If YES, please indicate reason _____
8. Do you have, or have had any disease, condition, or problems not listed? **Y/N**
   If YES, please list _____
9. WOMEN ONLY Are you Pregnant Y/N Are you Nursing Y/N Taking Birth Control Pills **Y/N**
10. **Last Routine Dental Checkup** (DD/MM/YYYY):_____
11. **Last Routine Cleaning** (DD/MM/YYYY):_____

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		Emphysema		Hemophilia	
Rheumatic Fever		Liver Disease		Sickle Cell Disease	
Stroke		Chemotherapy		Fainting/ Dizzy Spells	
Arthritis/ Rheumatism		Thyroid Issues		Epilepsy or Seizures	
Drug/ Alcohol Dependency		Neurological Disorders		Kidney Problems	
Nervous/ Anxious		Psychiatric care		Other:	

Consent to Photograph

I, _____ (name) give permission to Smiles Dental Group, and/or parties designated by Smiles Dental Group and/or 8 Cubed Holdings to take my photograph/ video and use this information in all forms of media, for any and all purposes including advertising, display, audiovisual, exhibition or editorial use.

OR I, _____ decline the use of my photos for the above-mentioned purposes.

Office Policies

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.

In order to provide direct billing to our patients, we will require our patients to provide us with a credit card on file. If we cannot calculate your balance at your dental visit with certainty, you will be required to pay 30%. 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. Initials:_____

Patient's medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. By completing this form you are consenting to the collection, use, and disclosure of your personal information when permitted or required by law. Initials:_____

In order to facilitate direct billing, you agree to your clinical records, images, and/or x-rays to be released to your insurance provider(s) should they request it, or to support pre-authorizations, or billings. You also agree to our office sending

_____ _____ _____

Date Name Signature

24-11-2024

Date

Print Name

Date

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

pre-authorizations, or communicating with your insurance company to request coverage details of your insurance plan in order to determine your level of coverage and your co-pay. Initials:_____

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 periodontal concerns. However, we require a commitment from you in order to achieve overall oral health. Initials:_____

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. **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 $100.00 ($250.00 for surgical procedures).** Initials:_____

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. Initials:_____

We require your signature below to indicate your consent to perform the dental and oral procedures 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.

_____ _____ _____

Date Name Signature

24-11-2024

Date
Print Name

Date