Foothills Dental Welcomes You!

We would like to officially WELCOME YOU to our dental office and thank you for choosing us as your comprehensive dental care provider.

Our office strives to provide quality, gentle care in a clean, comfortable and relaxed atmosphere. Our team of dedicated professionals will work together to ensure our patients receive the very best. At our office, your complete oral and dental care is our primary focus. We are committed to helping our patients achieve a lifetime of optimum oral health. It is essential to really listen to our patients and understand their needs and desires and to educate them so that they can take an active role in their treatment; together as a team, we can accomplish the smile you desire and maintain your oral health for a lifetime.

Office financial policies:

1. Many of our patients have dental benefits. While your dental benefit policy is an agreement between you and your insurance company, we will be happy to assist you in preparing and sending in the necessary forms. All professional services are billed directly to you and you are ultimately responsible for payment of the full fee amount. As a courtesy we will accept reimbursement from your insurance company. You will be responsible for any remaining portion the insurance company does not cover. Keep in mind that benefits may not cover 100% of your dentistry, even if you have 100% coverage on your plan. We are glad to assist in helping you understand your dental benefits and getting the most from your plan. Please let us know if your insurance information changes.

2. Appointment times are reserved exclusively for each patient. If for any reason you need to reschedule an appointment, we require two full business days' notice. Another patient who needs our care could be scheduled if we have sufficient time to notify them. Unless an emergency occurs you can expect us to be on time. We would appreciate the same courtesy. If you are late, we may have to reschedule your appointment so that other patients are not kept waiting. For missed appointments or short notice cancellations a fee may apply.

3. It is the responsibility of each patient to remember the date and time of their appointment. As a courtesy we provide a reminder phone call two days prior to the appointment. For appointments that have been booked more than a month in advance, we attempt to call two weeks prior to the appointment. We ask that you call us back to confirm the appointment day and time if we were unable to speak to you personally.

4. I understand that all records pertaining to the treatment and diagnosis of are the property of our dental office. Records and X-rays will be duplicated upon request with a customary fee applied for duplication.

5. During the course of my dental care unforeseen complications or new conditions may arise that may affect your original estimate. Every effort will be made to explain any changes to the treatment plan/cost estimate.

6. From time to time it may be necessary to refer you to a specialist so that you may receive the appropriate care. Should this occur, you will be billed directly by the specialist's office.

I understand the above office policies. Furthermore, I consent to the terms of this agreement and all of my questions regarding the office policies have been answered to my satisfaction.

PRINT NAME: ______________________________ WITNESS: ______________

SIGNATURE: ______________________________ DATE: ________________

FOOTHILLS DENTAL
FOR THE HEALTH OF your smile

PATIENT REGISTRATION / DENTAL HISTORY

Welcome to Foothills Dental. Please complete the following important information.
How did you hear about us: Radio? Newspaper? Google? Friend? Other? ________________

Contact Information:
Mr / Mrs / Ms / Miss / Dr (Please circle one)
Surname: _______________________ First Name: _______________________ Middle Initial:______
Preferred Name: ____________________ Gender: Male / Female Birthdate: ____________________
Mailing Address: ____ Postal Code: ____________
Home Phone: __________________ Cell Phone: ________________ Work Phone: _______________
Email Address: ____
Emergency Contact; __________________________ Emergency Phone Number: _________________
Relationship: ____

Responsible Party (For persons under 18 years of age)
Name: ________________________________ Relationship: _________________________________
Address: ____ Postal Code: ___________
Home Phone: __________________ Cell Phone: ________________ Work Phone: _______________

Insurance Information:
Primary Insurance Provider: ____
Secondary Insurance Provider: ____
Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this we require your authorization.

"I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to Foothills Dental."

_______ ____________________________________ ___________________________
Signature of Patient or Guardian of minor *Date*

FOOTHILLS DENTAL

Reason for Visit: ____
Last Dental Visit (date): _________________________ Treatment: ___________________________
Previous Dentist (name and location): ____
Last set of dental film/xrays (date): __________________________ Where: _____________________
Can we request these be sent to our office? ____

FOR THE HEALTH OF your smile

Please indicate Yes (Y) or No (N) to the following:

Do your gums bleed while brushing, flossing? ___
Are your teeth sensitive to hot/cold? ___
Are your teeth sensitive to sweet/sour? ___
Do you feel pain in any of your teeth? ___
Do you feel pain in any of your teeth? ___
Do you have sores/lumps in/near your mouth? ___
Have you had head/neck/jaw injuries? ___

Do you bite your lips/cheeks frequently? ___
Have you noticed any loosening of teeth? ___
Does food get caught between your teeth? ___
Have you had periodontal (gum) treatment? ___
Have you had oral hygiene instruction? ___
Have you had a difficult extraction? ___
Have you had prolonged bleeding? ___

Have you experience any of the following?
Clicking? ___ Pain (joint/ear/side of face)? ___ Difficulty opening/closing? ___ Difficulty Chewing ___

Do you have frequent headaches? ___
Do you clench or grind your teeth? ___

Do you wear dentures or partials? YES NO If yes, date placed _________________________
Do you have any dental implants? YES NO If yes, date placed _________________________
Have you had treatment from dental specialist? YES NO If yes, what type _______________________
Additional Comments ____

CONFIDENTIAL MEDICAL HISTORY

Patients Name: ________________________________ Contact Number: ____

Physician's Name _______________________________________ Clinic ____

1. Are you in good health? Yes ____ No ____ If no, please provide details

____

2. When was your last medical exam? ____

3. Are you presently receiving treatment for any illness? If yes please provide details

____

4. Have you ever been hospitalized? If yes please provide details

____

5. Do you have heart or circulatory problems? Yes_____ No____ If yes when ____

   Do you have a pacemaker? YES NO

6. Have you ever had rheumatic fever? Yes_____ No____ If yes, when ____

7. Have you ever been advised to take pre-medication prior to dental treatment? ____

8. Do you have any allergies? Seasonal/Hay Fever____________ Food ______________Medication __________________

   Other: Please specify ____

9. Are you presently taking any medication? If yes, please specify:

   Drug__________________________________ Reason ____

   Drug__________________________________ Reason ____

10. Have you ever had a reaction to any medication or dental local anesthetic? If yes please provide details __________________

____

11. Female patients – Are you pregnant or think you may be pregnant: YES NO Breastfeeding: YES NO

12. Please indicate below if you presently have or have ever had any of the following (please circle):

AIDS/HIV	Diabetes	Liver disease (Hepatitis/Jaundice)
Alcohol or chemical dependency	Eating disorders	Lung disease/chest pains
Arthritis or Rheumatism	Epilepsy/seizures	Mental or nervous disorders
Artificial joints or valves	Fainting/Dizzy spells	Stomach ulcers
Asthma	High/low blood pressure	Stroke
Blood Transfusion	Hyper/Hypo glycemia	Tuberculosis
Cancer/radiotherapy/chemotherapy	Kidney disease	Venereal/Communicable disease

13. Do you smoke? If yes, how many per day?_____________________ Per Week?_______________________

14. Do you grind or clench your teeth? Yes_________ No _________

15. Do you suffer from headaches______________ Earaches_____________ Neck aches ____________

16. Have been outside of Canada within the last 6 months? YES NO If Yes, Where _________________________________

17. Is there any additional information related to your health that has not been addressed above?

____

_________________________________ _______________ ____________________________ _____________

Patient or Guardian's Signature Date Reviewed By Date

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