



Bridgeland Dental Care
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Calgary, AB, T2E 9E1

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www.bridgelanddentalcare.com

PATIENT INFORMATION & PRIVACY FORM

Personal Information

Mr. Mrs. Ms. Miss Dr.

Patient's Name _____

Phone (primary) _____ Work Phone _____

Preferred First Name _____ Date of Birth ____/____/____

E-Mail Address _____

Parent / Guardian (if under 18) _____

How did you find out about our office? _____

Address _____

Emergency Contact _____

City _____ Province _____ Postal Code _____

Phone (primary) _____ Phone (secondary) _____

Medical History

Family Physician _____ Phone _____

Pharmacy _____ Phone _____

Are you now under the care of a physician? Yes No

If so, what is the condition being treated? _____

Are you taking any drug or medicine? Yes No

If so, please list _____

Do you have any drug allergies or reactions? Yes No

If so, please list _____

Have you ever had abnormal bleeding from previous extractions, surgery or trauma? Yes No

Are you pregnant or might you be pregnant? Yes No

Please check any of the following that you have had:

- | | |
|--|--|
| <input type="radio"/> Rheumatic fever or rheumatic heart disease | <input type="radio"/> Asthma |
| <input type="radio"/> Congenital heart lesions, blood or clotting disorder | <input type="radio"/> Lung or breathing disorders |
| <input type="radio"/> Heart trouble, heart attack, high blood pressure or stroke | <input type="radio"/> Kidney disease |
| <input type="radio"/> Chest pains or shortness of breath | <input type="radio"/> Hepatitis, jaundice or liver disease |
| <input type="radio"/> Fainting spells or seizures (eg. epilepsy) | <input type="radio"/> Nervous disorder |
| <input type="radio"/> Diabetes (diet or insulin controlled) | <input type="radio"/> Cancer |
| <input type="radio"/> Endocrine disorder (eg. thyroid disease) | <input type="radio"/> AIDS / HIV |
| <input type="radio"/> Gastrointestinal disease (eg. ulcers) | <input type="radio"/> Heart murmur |
| <input type="radio"/> Bone, muscle or joint disorder (eg. arthritis) | |

Do you have any disease or medical problem not listed above? Yes No

If so, please list _____

Dental Information

What dental condition concerns you at present? _____

Date of last dental visit _____ Former Dentist _____

Are you nervous about receiving dental treatment? Yes No

What is the one most important concern to you regarding dentistry?

Cost Time Appearance Discomfort

Are you happy with the appearance of your teeth? Very Fairly No

Financial arrangements: Cash Visa MasterCard Debit

Terms and Conditions

Office Policy

Payment is required each time service is rendered. A scheduled appointment is specifically reserved for you. Please be advised, to avoid a \$50.00 charge we require two (2) business days notice to change a scheduled appointment.

Patient Approval for Treatment and Fees

I consent to oral and dental procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures. I agree to pay all amounts not paid by my insurance plan. I further agree to let the dentist know if my medical status or insurance plan changes. I have been advised this office uses digital radiographs and these records will be transferred electronically in the event that I am referred to a specialist. I understand it can not be guaranteed that these transmissions are secure.

I agree with these terms

I certify that the information given here is correct

* Please fill out all fields and supply any other applicable information. Although some questions may seem unimportant at the moment, they are vital in case of an emergency.

X
Signature

X
Date