Synergy Periodontics Calgary

YOUR IMPLANT & DENTURE CENTRE

Name: _____ Today's Date: _____
Address: _____ City/Postal Code:_____/_____
Phone: Hm: _____ Cell: _____
Date of Birth: _____ Sex: M F Email: _____
Health Care No:_____ Employer: _____
Emergency Contact: _____ Phone: _____

Physician:_____ Phone: _____ Previous Dentist: _____ Phone: _____

Who can we thank for referring you to our clinic?_____

MEDICAL HISTORY

When did you last see your physician, and for what reason?_____
Do you have any drug allergies that you are aware of? Yes_____ No_____
Please list: _____
Do you have a Latex allergy? Yes_____ No_____
Have you ever been hospitalized? Yes_____ No_____
If Yes, for what reason?_____
Are you taking any medications or supplements? Yes_____ No_____
If yes, please list:_____
Did a dentist, physician or specialist ever recommend taking antibiotics prior to dental treatment or surgery?
Yes_____ No_____

Please circle any of the following conditions that apply to you, past or present.

Anemia	Diabetes	HIV/AIDS	Rheumatic Fever
Arthritis	Drug Use	High Blood Pressure	Sinus Problems
Artificial Joints	Epilepsy	Jaundice	Sleep Apnea
Asthma	Fainting	Kidney Disease	Snoring
Blood Disorders	Gastrointestinal	Liver Problems	Stroke
Breathing Problems	Growth or Tumour	Low Blood Pressure	Surgery
Cancer	Heart Attack	Mental/Nervous Disorders	Thyroid Problems
Clotting/Bleeding Problems	Heart Disease	Migraines/Headaches	Tuberculosis
Cold Sores	Heart Murmur	Osteoporosis	Ulcers
Depression	Hepatitis A-B-C	Pacemaker	

Is there anything else you would like us to know about your health? _____

Women: Are you pregnant? Yes_____ No_____ Birth Control or HRT? Yes_____ No_____ Are you in peri-menopause or menopause? Yes_____ No_____

APPOINTMENT POLICY

We would like to ask your help in providing a minimum of **TWO BUSINESS DAYS NOTICE** if for any reason you will be unable to keep a scheduled appointment. This consideration allows us to accommodate those patients that may be waiting for an appointment.

If you are unable to provide notice, there will be a $100.00 short notice cancellation fee.

For your convenience, we will continue to call or email you prior to your appointment to remind you of your visit.

I,_____, have read & understand the above policy.

Date:_____ Signature:_____

DENTAL HISTORY

Purpose of visit today: _____

Have you ever experienced any of the following?

Does you jaw click or Hurt? Y/N
Do you think you grind your teeth? Y/N
Have you ever had orthodontic treatment? Y/N
Do you wear a night guard? Y/N
Have you ever had gum disease? Y/N
Have you ever had your bite adjusted? Y/N
Do you bite your cheeks or lips often? Y/N
Does your mouth often seem dry? Y/N

Do you smoke? Y/N
Do you ever have bad breath? Y/N
Do your gums bleed when you brush? Y/N
Do you experience hot/cold sensitivity? Y/N
Does floss ever tear between your teeth? Y/N
Does food get stuck between your teeth? Y/N
Do your teeth hurt when you bite hard? Y/N
Have you been told you have deep pockets? Y/N

Are any of your teeth sensitive or aching? Yes_____ No_____ Which tooth/area? _____

When was your last visit to a dental office?_____ Last professional cleaning? _____ Last X-rays? _____

What is your dental comfort level on a scale of 1 to 10?
(not comfortable) 1 2 3 4 5 6 7 8 9 10 (Completely comfortable)

How often do you brush your teeth? ___ Floss? ___ Do you use: Mouthwash, Toothpicks, Proxy-brush, Floss threaders ?

Any other condition related to the health of your gums? _____

The following list of symptoms can be a sign of TMJ/TMD or bite problems. Please circle any that may apply to you.

Back/Neck Pain	Ear Congestion	Insomnia	Tender/sensitive Teeth
Bell's Palsy	Facial Pain	Joint Popping/Clicking	Tingling in Fingertips
Clenching	Grinding	Limited Opening	TM Joint Pain
Difficulty Chewing	Headaches	Loose Teeth	Trigeminal Neuralgia
Difficulty Swallowing	Hot/Cold Sensitivity	Ringing in the Ears (Tinnitis)	

Is there anything you would like to make us aware of that has not been covered on this form?

_____

DENTAL INSURANCE

Synergy Perio Calgary offers direct billing, we do require a credit card on file so we can process the difference as soon as we receive payment. At the time of your appointment, if applicable, your insurance will be processed electronically. If your insurance informs us of their payable portion at the time of service, you will be asked to pay any remaining balance. If no payable portion is available a 30% deposit will be taken.

Primary

Employer:_____ Provider:_____ Group:_____ ID#:_____

Secondary

Employer:_____ Provider: _____ Group: _____ ID#: _____

**If the insurance belongs to your spouse, please add Name:_____ DOB:_____*

PERMISSION TO TREAT, RELEASE OF INFORMATION & POLICY

I hereby authorize the doctor or designated team to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand I can ask for a complete recital of any possible complications. ***I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependents that isn't covered by insurance.***

Patients/Guardian Signature:_____ Date:_____