Integrity Dental

ALERTS	PREMEDS

Patients Last Name:	First Name:	Middle:
Birth date: M / D / Y	Sex: M F O	Marital Status: S M D CL Other
Billing Name:		
Billing Address:		
City:	Province:	Postal Code:
Contact Info – Home # :	Cell # :	
Emergency Contact:	Emergency Contact # :	
Employer :	Work # :	
Occupation:	Who referred you to us?	
Dental Decisions made by: SELF GUARDIAN TRUSTEE		
Guardian/Trustee Name:	Contact #:	
Family Physician:	Medical Office & #:	
Dental Insurance Company:		
Email Address:		

Patient Consent I hereby authorize the Dentist to take x-rays, study models, photographs or any other diagnostic aids deemed necessary by him to make a thorough diagnosis of my/my child's dental needs. I also authorize the Dentist to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk. I authorize appointment reminders to be sent to me by phone, text or email.

Signature of patient or guardian: ______________________________ Date: ______________________ Staff Initial: ________

Assignment of Benefits and Payment Policy Our office **DOES** accept assignment but dental plans today are so numerous and varied that we are unable to know the details of all of them. Your particular dental plan **may** or **may not** cover the full cost your dental treatment. This can occur because the fees in our office are based on factors that may not have been considered by your insurance carrier or there may be certain procedures which are not covered by your dental plan.

**** PLEASE REVIEW YOUR DENTAL PLAN VERY CAREFULLY TO ENSURE YOU UNDERSTAND THE EXCLUSIONS AND LIMITATIONS. ****

IF YOUR INSURANCE COMPANY **DOES NOT** COVER THE FULL COST OF THE TREATMENT IT BECOMES **YOUR RESPONSIBILITY TO PAY** ANY DIFFERENCE BETWEEN THE AMOUNT PAID BY YOUR PLAN AND THE AMOUNT CHARGED FOR YOUR TREATMENT.

PAYMENT FOR YOUR DENTAL SERVICES IS EXPECTED IMMEDIATELY FOLLOWING YOUR DENTAL APPOINTMENT.

I authorize the dentist to release information to the insurance company to assist in payment of benefits directly to the dental office. I authorize the dentist to use my records if he/she so determines.

I authorize Integrity Dental to securely hold a valid credit card on file to be used on any outstanding balances.

I certify that I have read the contents of this form and filled it out accurately and realize the risks and limitations involved.

Signature of Patient/Guardian: ______________________________ Date: ___________________________ Staff Initial________

DENTAL HISTORY

Yes	No	
☐	☐	Do you have dental pain?
☐	☐	Do you think you have gum problems?
☐	☐	Do you clench your teeth often?
☐	☐	Do you notice popping, clicking or soreness of the jaw or just in front of your ears?
☐	☐	Do you have head or neck pain or discomfort?
☐	☐	Have you had an injury to your face or jaws?
☐	☐	Are you involved in any contact sports (i.e. hockey, football, boxing, basketball)?
		Have you ever had problems with:
☐	☐	dental freezing/local anesthetic?
☐	☐	excessive bleeding with dental treatment?
☐	☐	nervousness about dental treatment?
☐	☐	a bad experience in a dental office?

When was your last dental visit: ______________________

When were your last X-rays taken: ______________________

Who was your last dentist: ______________________

What was your last dental treatment:

____

What concerns you the most about your teeth?

____

____

____

MEDICAL HISTORY

CLINIC | PHONE

Do you have a current medical problem? No ☐ Yes ☐ If "yes" indicate what problem:

____

1. Have you been hospitalized or had a serious illness within the last 5 years? Yes ☐ No ☐

If yes, why/what: ______________________

2. Do you have or have you had any of the following:

Heart or circulatory
- ☐ heart failure
- ☐ heart attack
- ☐ heart murmur
- ☐ congenital defect
- ☐ artificial valve
- ☐ pacemaker
- ☐ stroke
- ☐ rheumatic fever
- ☐ angina
- ☐ high blood pressure
- ☐ shortness of breath
- ☐ other ______________

Lung or breathing
- ☐ asthma
- ☐ tuberculosis
- ☐ allergies
- ☐ sinus trouble
- ☐ persistent cough
- ☐ other ______________

Contagious diseases
- ☐ cold sores
- ☐ HIV / AIDS
- ☐ venereal disease
- ☐ hepatitis
- ☐ other ______________

Nervous or brain
- ☐ migraines
- ☐ epilepsy
- ☐ seizures
- ☐ fainting, dizzy spells
- ☐ brain injury
- ☐ multiple sclerosis
- ☐ other ______________

Blood disorders
- ☐ hemophilia
- ☐ sickle cell anemia
- ☐ leukemia
- ☐ other ______________

Other
- ☐ thyroid disease
- ☐ glaucoma
- ☐ kidney disease
- ☐ artificial joint
- ☐ diabetes
- ☐ ulcers
- ☐ tumors
- ☐ arthritis
- ☐ jaundice or liver disease
- ☐ steroid therapy
- ☐ diet pill therapy
- ☐ drug/alcohol dependency
- ☐ diarrhea
- ☐ undiagnosed skin rash
- ☐ other ______________

3. Are you allergic to, or have you been told not to take: ______________
- ☐ antibiotics ______________
- ☐ painkillers ______________
- ☐ aspirin ______________
- ☐ local anesthetics ______________
- ☐ sedatives ______________
- ☐ latex materials ______________
- ☐ other: ______________

4. Are you:
- ☐ on a prescribed diet
- ☐ taking herbal supplements
- ☐ a smoker
- ☐ an ex-smoker
- ☐ nursing
- ☐ pregnant
- ☐ expected delivery date: ______________

5. Are you presently taking any medication? Yes ☐ No ☐

If yes, please list: ______________________

6. Do you require pre-medication for Dental treatment? Yes ☐ No ☐

If yes, what: ______________________

7. Is there anything else we should be aware of regarding your health? Has there been any change in your general health in the past year? ______________________

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The Information I have given above is true to the best of my knowledge

Patient Signature______________________ Date______________