SOUTH CALGARY ENDODONTICS
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Patient's History and Information

(Circle one) Mr/Mrs/Ms/Dr **Patient Name:** _____

Date of Birth: D____ M____ Y_____ **Alberta Health Care #:**_____

Home Address: _____

City: _____ **Prov:** _____ **Postal Code**_____

Phone Number (h): _____ **(w):**_____ **(c):** _____

Email: _____ **Preferred to be contacted via:** _____

Referring Dentist: _____ **Phone Number:** _____

If Patient is a minor, who is legally responsible? _____

Emergency Contact: _____ **Relationship:** _____

Are you presently being treated by a Physician? Y __ N __ **Family Physician:** _____

When was your last medical check-up? _____

Are you currently taking any medications? Y __ N __, if yes please list: _____

DO YOU NOW HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please Circle)

Heart Disease/Murmur/Angina	Thyroid Condition	Anxiety
Pacemaker	Adrenal Gland Issues	Bone Disorder/Osteoporosis
Swollen Ankles	Diabetes	Eating Disorder
High Blood Pressure	Cancer, Type: _____	Stroke/Transient Ischemic Shock
Low Blood Pressure	Seizures/Epilepsy	Radiation/Chemotherapy
High Cholesterol	Neurological Condition	Steroid Therapy
Kidney Disease/Bladder Issues	Psychiatric Care	Lung Condition/Asthma/Cough
Stomach Issues/Ulcer	Depression	Headaches/Migraines
Reflux Issues/Ulcerative Colitis	Hearing Loss/Ear Condition	Arthritis/Muscle Weakness
Blood Pressure Problems/Anemia	Sinus Problems	Allergies: _____
Liver Disease/Hepatitis	Malignant Hyperthermia	_____
Alcohol Dependency	HIV/Aids	_____

Please Explain: _____

_____

_____

Women: Are you Pregnant? : _____
Please inform our office if you become pregnant during the course of treatment.

Do you have Dental Coverage? Y _____ N ____

FINANCIAL RESPONSIBILITY:

I assume full responsibility of the services rendered in this office, and agree to pay in full, at or before completion of treatment, unless other arrangements are agreed upon, in advance. To avoid misunderstanding regarding dental insurance, we wish our patients to know that ALL PROFESSIONAL SERVICES ARE CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES.

Date: _____ Signature: _____ Reviewed by: _____

CONSENT FOR TREATMENT:

I, the undersigned, being the patient, parent or guardian of the above minor patient, consent to undergo whatever endodontic treatment procedures are deemed necessary or advisable in the opinion of the doctor.

I understand that root canal therapy is an attempt to retain a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment surgery, or even extraction. I further understand that the FINAL RESTORATION of the tooth (with a filling, inlay, crown etc.) will be done by my regular dentist AT AN ADDITIONAL FEE.

Date: _____ Signature: _____ Reviewed by: _____

PRIVACY POLICY:

It is our policy to keep all information you have provided to us confidential. Information you have provided us is used for diagnostic and billing/insurance purposes only. We will share and provide information on a need to know basis to insurance companies, your dentist or health care providers as part of the care we provide you. Please sign this to acknowledge and accept this privacy policy.

Date: _____ Signature: _____