Welcome to Alexander Dental – Tell Us About Yourself

********** ALL INFORMATION IS CONFIDENTIAL **********

alexander DENTAL CENTER

HAPPY HEALTHY SMILES

Name: _____ _____ _____

Last *First* *MI*

Preferred Name: _____ DOB: _____ Male ☐ Female ☐

Address: _____ City: _____ Province: _____ Postal Code: _____

Email Address: _____ Home Phone: _____ Work Phone: _____ Cell: _____

Employer: _____ Occupation: _____

How did you hear about our office? _____

How do you prefer to be contacted for appointment confirmation? Email ☐ Phone ☐

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone: _____ Cell: _____

INSURANCE – PRIMARY

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Insurance Company: _____

INSURANCE – SECONDARY

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Insurance Company: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Alexander Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

***Consent**: I consent to the diagnostic procedures and treatment by the dentist/dental hygienist necessary for proper dental care.*

Patient (Parent/Guardian) Signature: _____

If Parent/Guardian please print name: _____

MEDICAL HISTORY

Do you have a personal physician: Yes ☐ No ☐

Physician's Name: _____ Phone: _____ Date of Last Visit: _____

Are you currently under the care of a physician: Yes ☐ No ☐

Please explain: _____

Do you smoke: Cigarettes ☐ Cigars ☐ Pipe ☐ Chew Tobacco ☐ Other ☐ How many daily? _____

Have you had any metal rods, pins or implants placed: Yes ☐ No ☐ If yes, where? _____

Are you taking any medications: Yes ☐ No ☐ If yes, please list which ones and what they are for: _____

_____

_____

Have you ever had any surgical procedures? Yes ☐ No ☐

If yes, please list each one: _____

Do you have any complications with anesthesia? Yes ☐ No ☐ If yes, please explain: _____

_____

Yes	No	**Conditions**	Yes	No	**Conditions**	Yes	No	**Allergies**
☐	☐	Abnormal Bleeding	☐	☐	Heart Murmur	☐	☐	Aspirin
☐	☐	Alcohol Abuse	☐	☐	Heart Surgery	☐	☐	Codeine
☐	☐	Allergies	☐	☐	Hemophilia	☐	☐	Dental Anesthetics
☐	☐	Anemia	☐	☐	Hepatitis A	☐	☐	Erythromycin
☐	☐	Angina Pectoris	☐	☐	Hepatitis B	☐	☐	Jewelry
☐	☐	Arthritis	☐	☐	Hepatitis C	☐	☐	Latex
☐	☐	Artificial Heart Valve	☐	☐	High Blood Pressure	☐	☐	Metals
☐	☐	Asthma	☐	☐	Joint Replacement	☐	☐	Penicillin
☐	☐	Blood Transfusion	☐	☐	Kidney Replacement	☐	☐	Tetracycline
☐	☐	Cancer	☐	☐	Liver Disease			
☐	☐	Chemotherapy	☐	☐	Low Blood Pressure			
☐	☐	Colitis	☐	☐	Mitral Valve Prolapse	**If Female, Please Answer**		
☐	☐	Congenital Heart Defect	☐	☐	Pace Maker	Taking birth control? Yes ☐ No ☐		
☐	☐	Diabetes	☐	☐	Phsychiatric Problems	Are you pregnant? Yes ☐ No ☐		
☐	☐	Difficulty Breathing	☐	☐	Radiation Therapy	If so, # of weeks _____		
☐	☐	Drug Abuse	☐	☐	Rheumatic Fever	Are you nursing? Yes ☐ No ☐		
☐	☐	Emphysema	☐	☐	Seizures			
☐	☐	Epilepsy	☐	☐	Sexually Transmitted Disease			
☐	☐	Facial Surgery	☐	☐	Shingles			
☐	☐	Fainting Spells	☐	☐	Sickle Cell Disease			
☐	☐	Fever Blisters	☐	☐	Sinus Problems			
☐	☐	Frequent Headaches	☐	☐	Stroke			
☐	☐	Glaucoma	☐	☐	Thyroid Problems			
☐	☐	HIV + AIDS	☐	☐	Tuberculosis			
☐	☐	Heart Attack	☐	☐	Ulcers			

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

DENTAL HISTORY

How may we help you today? _____

Your current dental health is: Good ☐ Fair ☐ Poor ☐

Do you require antibiotics before dental treatment? Yes ☐ No ☐ If Yes Why?_____

Are you currently in pain? Yes ☐ No ☐

Have you ever had gum treatment? Yes ☐ No ☐

Do you now or have you had any pain/discomfort in your jaw joint? Yes ☐ No ☐

Are you under stress (ie: new job, moving)? Yes ☐ No ☐

Do you like your smile? Yes ☐ No ☐

If you could change your smile what would you change? _____

_____

Are you happy with the color of your teeth? Yes ☐ No ☐

Do your gums bleed? Yes ☐ No ☐

How many times do you? Floss/Week? _____ Brush/Day? _____

Are your teeth sensitive to hot or cold or anything else? _____

Have you lost any teeth? _____

Have you ever had a serious problem with any previous dental work? _____

_____

Have you ever had any unfavorable dental experience? _____

_____

When was your last Cleaning? _____

When was your last dental visit? _____

Why did you leave your previous dentist? _____

Here at Alexander Dental we offer a wide variety of services to enhance and keep your smile happy, healthy and beautiful. Please check any services below you would like our friendly staff to discuss with you during your visit.

Tooth Whitening ☐	Veneers ☐	Invisalign ☐
Traditional Orthodontics (Brackets) ☐	Smile Makeover ☐	Sealants ☐
Crowns ☐	Bridges ☐	Night/Sport Gaurds ☐

Any other service? _____

_____

_____