PRINCESS
DENTAL

Dr. Geoff McIntosh, DMD
Dr. Jill Gudmandson, DMD
Dr. Jessica Carswell, DMD
Dr. Dustin Wurm, DMD

PATIENT INFORMATION (Confidential)

First Name _____ Last Name _____ Birth date _____
Address _____ City _____ Prov _____ Postal Code _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ Marital Status _____
E-mail _____ Gender _____
Emergency Contact/Parent Contact _____ Phone # _____
How did you hear about us? _____
If you selected Family/Friend or other, whom shall we thank for your referral? _____

PRIMARY INSURANCE POLICY

Insurance Company _____ Policy # _____
Sub ID # _____
Policyholder's Name _____
Policyholder's Date of Birth _____
Place of Employment _____ Work Phone _____

SECONDARY INSURANCE POLICY

Insurance Company _____ Policy # _____
Sub ID # _____
Policyholder's Name _____
Policyholder's Date of Birth _____
Place of Employment _____ Work Phone _____

CREDIT CARD AUTHORIZATION

Our office will gladly direct bill your insurance company on your behalf. In order to direct bill your insurance company, we kindly ask that you leave an imprint of your credit card and any amounts not covered by your insurance company will be charged to your credit card and an email receipt sent. Please advise us of any future changes in your credit card.

I authorize Princess Dental Centre to process invoice charges to my:

☐ Visa ☐ Mastercard ☐ Amex (Debit/Visa or Debit credit cards are not accepted)

Credit Card #: _____ CCV# _____
Expiry Date: _____
Patient(s) on Account: _____
Name(s) of Patient That The Credit Card is Authorized For: _____
Cardholder First Name: _____ Last Name _____
Cardholder E-mail Address: _____
CardholderSignature: _____
Date: _____

The balance remaining after we have received your insurance benefits, will be charged to your credit card. This authorization will be in effect until notice of cancellation is forwarded in writing to Princess Dental Centre.

PRINCESS DENTAL

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

Patient Medical History

Physician _____ Physician's Office Phone_____

1. Are you currently under any medical treatment?_____ ☐ ☐
2. Have you been admitted to a hospital or needed emergency care during the past two years?_____ ☐ ☐
3. Are you currently taking any medications, including over the counter medications?_____ ☐ ☐
   Please list:_____
4. Have you ever had any complications following dental treatment?_____ ☐ ☐
5. Do you have or have had any of the following? Please check all that apply.

☐ AIDS/HIV	☐ Glaucoma	☐ Rheumatism
☐ Anemia	☐ Head Injuries	☐ Sinus Problems
☐ Arthritis	☐ Heart Disease/Angina	☐ Stomach Problems
☐ Artificial Joints	☐ Heart Murmur	☐ Stroke
☐ Asthma	☐ Hepatitis	☐ Tuberculosis
☐ Blood Disease	☐ High Blood Pressure	☐ Thyroid Disease
☐ Cancer	☐ Kidney Disease	☐ Tumors
☐ Diabetes	☐ Liver Disease	☐ Venereal Disease
☐ Dizziness	☐ Mental Disorders	☐ Smoker
☐ Drug/Alcohol Dependency	☐ Pacemaker	☐ Osteoporosis Medications
☐ Epilepsy	☐ Radiation Therapy	(e.g. Fosamax, Actone)
☐ Excessive Bleeding	☐ Respiratory Problems	☐ None of These
☐ Fainting	☐ Rheumatic Fever	

6. Are there any conditions or diseases not listed above that you have or ever had? ☐ ☐
   If yes, please explain:_____
7. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, or heart disease) If yes, please explain: _____ ☐ ☐
8. Do you have a history of snoring/sleep apnea?_____ ☐ ☐
   If so do you use a mouth breather? _____ ☐ ☐
   Do you often find it difficult to breathe through your nose?_____ ☐ ☐
9. WOMEN ONLY: Are you breast feeding? _____ ☐ ☐
10. Are you pregnant?_____ ☐ ☐
11. What is your due date?_____
12. Do you have any allergies to medications? _____ ☐ ☐
13. Please list your allergies to any medications:_____

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PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)_____ ☐ ☐

2. Have you had an unfavorable dental experience?_____ ☐ ☐
3. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____ ☐ ☐
4. Did you ever have braces, orthodontic treatment, or had your bite adjusted?_____ ☐ ☐
5. Have you had any teeth removed or missing teeth that never developed?_____ ☐ ☐

GUM AND BONE

6. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
7. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _ ☐ ☐
8. Have you ever noticed an unpleasant taste or odor in your mouth?_____ ☐ ☐
9. Is there anyone with a history of periodontal disease in your family? If so indicate who: _____
_____ ☐ ☐
10. Have you ever experienced gum recession? _____ ☐ ☐
11. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?_____ ☐ ☐
12. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ___ ☐ ☐

TOOTH STRUCTURE

13. Have you had any cavities within the past 3 years?_____ ☐ ☐
14. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?_____ ☐ ☐
15. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
16. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ____ ☐ ☐
17. Do you have grooves or notches on your teeth near the gum line?_____ ☐ ☐
18. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
19. Do you frequently get food caught between any teeth?_____ ☐ ☐

BITE AND JAW JOINT

20. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
21. Do you feel like your lower jaw is being pushed back when you bite your teeth together?_____ ☐ ☐
22. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
23. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
24. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
25. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
26. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?_____ ☐ ☐
27. Do you place your tongue between your teeth or close your teeth against your tongue?_____ ☐ ☐
28. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ___ ☐ ☐

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PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

29. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
30. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?_____ ☐ ☐
31. Do you wear or have you ever worn a bite appliance?_____ ☐ ☐

SMILE CHARACTERISTICS

32. Is there anything about the appearance of your teeth that you would like to change?_____ ☐ ☐
33. Have you ever whitened (bleached) your teeth?_____ ☐ ☐
34. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
35. Have you been disappointed with the appearance of previous dental work?_____ ☐ ☐

FOR SEDATION PATIENTS ONLY

36. What is your height?_____What is your weight?_____ ☐ ☐
37. Do you have glaucoma?_____ ☐ ☐
38. Do you have a history of snoring/sleep apnea? _____ ☐ ☐
    If so do you use a home CPAP machine?_____ ☐ ☐
    Are you a mouth breather?_____ ☐ ☐
    Do you often find it difficult to breathe through your nose?_____ ☐ ☐
39. Have you received treatment for alcohol or drugs use? _____ ☐ ☐
40. Do you use narcotics or sedatives on a regular basis?_____ ☐ ☐
41. Do you use recreational drugs?_____ ☐ ☐
42. Is there any problem or medical condition that you wish to discuss in private only?_____ ☐ ☐

CONSENT FOR SERVICES

I, the undersigned, also certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary to obtain information that is required for my dental care.

I agree to pay value of said services which shall be as billed, unless objected to by me, in writing, within the time for payment thereof. I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand my personal information disclosed is protected by the Privacy Act. I agree that Princess Dental Centre can electronically file dental claims on my behalf.

I have read the above conditions of treatment and payment and agree to their content.

Signature_____ Date_____

(Patient, Parent, or Guardian)