

P: 780 306 9333 F: 780 306 9222 218 – 5540 Windermere Blvd NW Edmonton, AB T6W 2Z8 www.flossophydental.ca info@flossophydental.ca

CANCELLATION POLICY

WE understand that with everyone's increasingly busy lives, conflicts with your scheduled appointment times can and will occur.

IN order to provide **YOU**, our patients, with prompt patient care and attention, we must ask that you provide our office with at least 48 hours' notice prior to your appointment should you need to reschedule.

PLEASE arrive on time for your appointment. If you arrive later than 15 minutes after your appointment time, we may not be able to see you that day or complete your full treatment. We will make every effort to accommodate you, however in some cases your appointment may have to be rescheduled.

IMPORTANT If you fail to provide us with the required 48 hour cancellation notice, there will be a cancellation fee of \$50 per hour of your appointment time charged to you.

PERSONAL INFORMATION

Name _____

(Last)	(FIRST)		Please Circle Month Day Year		
			Postal Code		
Employer		Occupation	SIN		
Marital Status Spouse Name		e	Alberta Health Care		
Phone H	W	C	Email		
Can we contact & confirm	n your appointments by	Email □ Yes □ No	Text Message □ Yes □ No		
Best way to contact you is	s 1 st	2 nd	3rd		
How did you hear about	our office or did somebody	refer you?			
Emergency Contact Name	e & Number				
Dental Insurance					
Primary Insurance Name		Se	econdary Insurance Name		
Group/Policy #		Gı	Group/Policy #		
I.D/Certificate #		I.C	I.D/Certificate #		
Plan holder name		Pl.	Plan holder name		
Plan holder D.O.B		Pl.	Plan holder D.O.B		
Plan holder relation to patient		PI	Plan holder relation to patient		
Patient Consent:					
1		, ,	re permission to flossophy dental and staff to perform den		
•			I would be responsible for t stated above. I authorize the release, to my dental benefits pl		
' '		, ,	ctronically/ manually. I also authorize the communication		
			al. I hereby assign my benefits, payable from claims submitt		
electronically to flossophy	dental and authorize paym	nent directly to them.			
ent / Parent / Guardian's Sigr	nature		Date		



MEDICAL HISTORY

Patient / Parent / Guardian's Signature ____

				Age
١	ame of Physician and their specialty		Most recent physical examination	
	/hat is your estimate of your general health? □ Excellent	□ Good □ Fai	r 🗖 Poor	
	LEASE CHECK IF YOU HAVE or EVER HAD:			
	Hospitalization for illness or injury	🗆	27.	Arthritis
	An allergic reaction to		28.	Autoimmune disease
	 Aspirin, ibuprofen, acetaminophen, codeine 			(rheumatoid arthritis, lupus, scleroderma)
	☐ Penicillin		29.	Glaucoma
	☐ Erythromycin		30.	Contact lenses
	☐ Tetracycline		31.	Head or neck injuries
	☐ Sulfa		32.	Epilepsy, convulsions (seizures)
	☐ Local anesthetic		33.	Neurologic disorders (ADD/ADHD, prion disease)
	☐ Fluoride		34.	Viral infections and cold sores
	☐ Metals (nickel, gold, silver)		35.	Any lumps or swelling in the mouth
	☐ Latex		36.	Hives, skin rash, hay fever
	Other		37.	STI/STD/HPV
	Heart problems, or cardiac stent within the last six months		38.	
	History of infective endocarditis			HIV/AIDS
	Artificial heart valve, repaired heart defect (PFO)		40.	Tumor, abnormal growth
	Pacemaker or implantable defibrillator		41.	Radiation therapy
	Orthopedic implant (joint replacement)			Chemotherapy, immunosuppressive medication
	Rheumatic or scarlet fever		43.	Emotional difficulties
	High or low blood pressure		44.	Psychiatric treatment
	A stroke (taking blood thinners)		45.	Antidepressant medication
	Anemia or other blood disorder			Alcohol/recreational drug use
	Prolonged bleeding due to a slight cut (INR>3.5)		40.	Alcohol/Teereational arag ase
	Emphysema, shortness of breath, sarcoidosis		A DE	YOU
	Tuberculosis, measles, chicken pox			
	Asthma		47.	, , ,
	Breathing or sleep problems (sleep apnea, snoring, sinus)		48.	Aware of a change in your health in the last 24 hours
	Kidney disease			(fever, chills, new cough, diarrhea)
	Liver disease		49.	Taking medication for weight management
	Jaundice		50.	Taking dietary supplements
	Thyroid, parathyroid disease, or calcium deficiency		51.	Often exhausted or fatigued
	Hormone deficiency		52.	Experiencing frequent headaches
	High cholesterol or taking statin drugs		53.	A smoker, smoked previously or use smokeless tobacco
	Diabetes (HbA1c=)		54.	Considered a touchy/sensitive person
	Stomach or duodenal ulcer		55.	Often unhappy or depressed
	Digestive disorders (celiac disease, gastric reflux)		56.	Taking birth control pills
	Osteoporosis/osteopenia (i.e. taking bisphosphonates)			Currently pregnant
			58.	Prostate disorders

_____ Date ____



Dental History

How would your rate the condition of your mouth?	Patients	Name	Age		
Date of most recent veral exame. Date of most recent veral exament (other than a cleaning) Troutinely see my dentital every 3 months 4 months 6 months 12 months Not routinely What is your immediate concern? PERSONAL HISTORY A rely ou had an unfavorable dental experience?	How wor	uld you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor			
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Date of most recent treatment (other than a cleaning)		·			
PERSONAL HISTORY					
PERSONAL HISTORY 1. Are you feaful of dental treatment? How feaful, on a scale of 1 (least) to 10 (most) [1			et		
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11. Have you ever experienced gum recession? 12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? 13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? TOOTH STRUCTURE 14. Have you had any cavities within the past 3 years? 15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? 16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? 17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? 18. Do you have grooves or notches on your teeth near the gum line? 19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? 20. Do you frequently get food caught between any teeth? 21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) 22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? 23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? 24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? 25. Are your teeth becoming more crooked, crowded, or overlapped? 26. Are your teeth becoming more crooked, crowded, or overlapped? 27. Do you have more than one bite, squeeze, or shift you jaw to make your teeth fit together? 28. Do you chew ice, bite your nalls, use your teeth or close your teeth against your tongue? 29. Do you chew ice, bite your nalls, use your teeth or loose your teeth against your tongue? 30. Do you clench your teeth in the daytime or make them sore? 31. Do you ware or have you ever worn a bite appliance? 32. Shille CHARACTERISTCS 33. Is there anything about the appearance of your teeth that you would like to change? 34. Have you ever whitened (bleached) your teeth? 35. Have you ever whitened (bleached) your teeth?		Is there anyone with a history of periodontal disease in your family?			
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36. Have you been disappointed with the appearance of previous dental work?					
	36.	Have you been disappointed with the appearance of previous dental work?			

Patient / Parent / Guardian's Signature ______ Date ____