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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) Gender M / F (Please Circle) Date of Birth ______ (Month) / ______ (Day) / ______ (Year)

Address ____ Postal Code ______________

Employer ______________________ Occupation ______________________ SIN ______________

Marital Status ______________ Spouse Name ______________________ Alberta Health Care______________

Phone H ______________ W ______________ C ______________ Email ______________________

Can we contact & confirm your appointments by Email ◻ Yes ◻ No Text Message ◻ Yes ◻ No

Best way to contact you is 1st ______________________ 2nd ______________________ 3rd ______________________

How did you hear about our office or did somebody refer you? ____

Emergency Contact Name & Number ____

Dental Insurance

Primary Insurance Name ______________________	Secondary Insurance Name ______________________
Group/Policy # ______________________	Group/Policy # ______________________
I.D/Certificate # ______________________	I.D/Certificate # ______________________
Plan holder name ______________________	Plan holder name ______________________
Plan holder D.O.B ______________________	Plan holder D.O.B ______________________
Plan holder relation to patient ______________________	Plan holder relation to patient ______________________

Patient Consent:

I ________________________________ hereby give permission to flossophy dental and staff to perform dental treatment on myself / child / other (please state)________________________________. I would be responsible for the payment of my account. I have read and understood the cancellation policy as stated above. I authorize the release, to my dental benefits plan administrator and CDA, of information contained in claims submitted electronically/ manually. I also authorize the communication of information related to the coverage of services described, to flossophy dental. I hereby assign my benefits, payable from claims submitted electronically to flossophy dental and authorize payment directly to them.

Patient / Parent / Guardian's Signature ____ Date ______________________

MEDICAL HISTORY

Patients Name____________________________ Age ____________________

Name of Physician and their specialty____________________________ Most recent physical examination ____________

What is your estimate of your general health? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

PLEASE CHECK IF YOU HAVE or EVER HAD:

1. Hospitalization for illness or injury ____________ ❒
2. An allergic reaction to
   - ❒ Aspirin, ibuprofen, acetaminophen, codeine
   - ❒ Penicillin
   - ❒ Erythromycin
   - ❒ Tetracycline
   - ❒ Sulfa
   - ❒ Local anesthetic
   - ❒ Fluoride
   - ❒ Metals (nickel, gold, silver ________)
   - ❒ Latex
   - ❒ Other ________________
3. Heart problems, or cardiac stent within the last six months ________ ❒
4. History of infective endocarditis ____________ ❒
5. Artificial heart valve, repaired heart defect (PFO) ____________ ❒
6. Pacemaker or implantable defibrillator ____________ ❒
7. Orthopedic implant (joint replacement) ____________ ❒
8. Rheumatic or scarlet fever ____________ ❒
9. High or low blood pressure ____________ ❒
10. A stroke (taking blood thinners) ____________ ❒
11. Anemia or other blood disorder ____________ ❒
12. Prolonged bleeding due to a slight cut (INR>3.5) ____________ ❒
13. Emphysema, shortness of breath, sarcoidosis ____________ ❒
14. Tuberculosis, measles, chicken pox ____________ ❒
15. Asthma ____________ ❒
16. Breathing or sleep problems (sleep apnea, snoring, sinus) ________ ❒
17. Kidney disease ____________ ❒
18. Liver disease ____________ ❒
19. Jaundice ____________ ❒
20. Thyroid, parathyroid disease, or calcium deficiency ____________ ❒
21. Hormone deficiency ____________ ❒
22. High cholesterol or taking statin drugs ____________ ❒
23. Diabetes (HbA1c=________) ____________ ❒
24. Stomach or duodenal ulcer ____________ ❒
25. Digestive disorders (celiac disease, gastric reflux) ____________ ❒
26. Osteoporosis/osteopenia (i.e. taking bisphosphonates) ________ ❒
27. Arthritis ____________ ❒
28. Autoimmune disease (rheumatoid arthritis, lupus, scleroderma) ____________ ❒
29. Glaucoma ____________ ❒
30. Contact lenses ____________ ❒
31. Head or neck injuries ____________ ❒
32. Epilepsy, convulsions (seizures) ____________ ❒
33. Neurologic disorders (ADD/ADHD, prion disease) ________ ❒
34. Viral infections and cold sores ____________ ❒
35. Any lumps or swelling in the mouth____________ ❒
36. Hives, skin rash, hay fever ____________ ❒
37. STI/STD/HPV ____________ ❒
38. Hepatitis (type____________) ____________ ❒
39. HIV/AIDS ____________ ❒
40. Tumor, abnormal growth ____________ ❒
41. Radiation therapy ____________ ❒
42. Chemotherapy, immunosuppressive medication ____________ ❒
43. Emotional difficulties ____________ ❒
44. Psychiatric treatment ____________ ❒
45. Antidepressant medication ____________ ❒
46. Alcohol/recreational drug use ____________ ❒

ARE YOU

47. Presently being treated for any other illness ____________ ❒
48. Aware of a change in your health in the last 24 hours (fever, chills, new cough, diarrhea) ____________ ❒
49. Taking medication for weight management ____________ ❒
50. Taking dietary supplements ____________ ❒
51. Often exhausted or fatigued ____________ ❒
52. Experiencing frequent headaches ____________ ❒
53. A smoker, smoked previously or use smokeless tobacco ______ ❒
54. Considered a touchy/sensitive person ____________ ❒
55. Often unhappy or depressed ____________ ❒
56. Taking birth control pills ____________ ❒
57. Currently pregnant ____________ ❒
58. Prostate disorders ____________ ❒

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment (botox, collagen injections etc.)

____

____

List all medications (its purpose), supplements, and or vitamins taken within the last two years

____

____

____

PLEASE ASVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATION YOU MAY BE TAKING

Patient / Parent / Guardian's Signature ______________________________ Date ________________

Dental History

Patients Name ______________________ Age ______________________

How would you rate the condition of your mouth? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Previous Dentist ______________________ How long have you been a patient? ______________________

Date of most recent dental exam ______________________ Date of most recent x-rays ______________________

Date of most recent treatment (other than a cleaning) ______________________

I routinely see my dentist every ❒ 3 months ❒ 4 months ❒ 6 months ❒ 12 months ❒ Not routinely

What is your immediate concern? ______________________

____

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 complications from past dental treatment? ______________________ ❒
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ______________________ ❒
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ______________________ ❒
6. Have you had any teeth removed or missing teeth that never developed? ______________________ ❒

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ______________________ ❒
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______________________ ❒
9. Have you noticed an unpleasant taste or odor in your mouth? ______________________ ❒
10. Is there anyone with a history of periodontal disease in your family? ______________________ ❒
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? ______________________ ❒

BITE AND JAW JOINT

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 developing spaces or becoming more loose? ______________________ ❒
27. Do you have more than one bite, squeeze, or shift you jaw to make your teeth fit together? ______________________ ❒
28. Do you place your tongue between your teeth or close your teeth against your tongue? ______________________ ❒
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______________________ ❒
30. Do you clench your teeth in the daytime or make them sore? ______________________ ❒
31. Do you have any problems with sleep (i.e. restlessness); wake up with a headache or an awareness of your teeth? ______________________ ❒
32. Do you wear or have you ever worn a bite appliance? ______________________ ❒

SMILE 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 felt uncomfortable or self-conscious about the appearance of your teeth? ______________________ ❒
36. Have you been disappointed with the appearance of previous dental work?______________________ ❒

Patient / Parent / Guardian's Signature ______________________ Date ______________________