Nottingham Dental
WWW.NOTTINGHAMDENTAL.CA

664 WYE ROAD SUITE 330
SHERWOOD PARK AB T8A 6G3

OFFICE 780 467 2401
FAX 780 467 4362

Patient's Name: _____ _____ _____
(First) (Last) (Preferred)

Title: ☐ Mr. ☐ Mrs. ☐ Ms. **Gender:** ☐ Male ☐ Female **Status:** ☐ Married ☐ Single ☐ Child

Birth Date: mm/dd/yyyy **Alberta Health Care Number:** _____ **Occupation:** _____

Current Address: _____ _____ _____
(Street) (City/Town) (Postal Code)

Email Address: _____ **Preferred Method of Contact**: ☐ Phone/Text **or** ☐ Email

Phone Number: _____ _____ _____
(Home) (Cell) Work)

Family Doctor: _____ **Family Doctor's Phone:** _____

Emergency Contact: _____ _____
(Name) (Phone Number)

Insurance Information:

Primary Insurance Information

Insurance Company: _____

Group / Policy #: _____

ID/Cert #: _____ **Div #** _____

Policy Holder Full Name & DOB

_____ _____ _____
(Last) (First) (MM/DD/YR)

Secondary Insurance Information

Insurance Company: _____

Group / Policy #: _____

ID/Cert #: _____ **Div #** _____

Policy Holder Full Name & DOB

_____ _____ _____
(Last) (First) (MM/DD/YR)

How did you hear about us? ☐ Website ☐ Walk-by ☐ Social Media ☐ Family/Friend Referral [Name]

Previous Dental Clinic: _____ **Last Appointment:** _____

I request that my dental records, including radiographs, be mailed to Nottingham Dental at 330, 664 Wye Rd, Sherwood Park, AB T8A 6G3 or e-mailed to info@nottinghamdental.ca ☐ No ☐ Yes

Insurance Authorization and Authorized Consent to Release Information

Our office policy is that all dental services are paid in full on the day that services are rendered.
As a courtesy we will submit your insurance claim on your behalf, your insurance company will reimburse you.

_____ _____ _____
Name ***Signature*** ***Date***

Medical History

Has there been any change in your health in the past year?	□No □Yes. Explain:
Have you had a heart-attack in the last 6 months?	□No □Yes. Explain:
Have you been advised to take antibiotics prior to dental treatment?	□No □Yes. Explain:
Have you ever had a serious illness or surgery?	□No □Yes. Explain:
Are you allergic to or ever had a reaction to the following?	□Penicillin □Codeine □Local Anesthetic(“freezing”) □Aspirin □Sulfa Drugs □Other_____
Are you on a blood thinner?	□No □Yes. Type:
Have you ever received injectable medication for bone metabolism(e.g. osteoporosis)?	□No □Yes.
Are you taking any other prescription medications, non-prescribed drugs or supplements?	□No □Yes. List:
Females Only: Are you pregnant?	□No □Yes. Explain:

Do you have or ever had any of the following conditions? Please check all that may apply.

□Heart Problems or Stroke □Heart Murmur □Thyroid Disorder □Rheumatic □Fever □Breathing Problems □Arthritis □HIV Positive □Tumours or Cancer □High Blood Pressure □Low Blood Pressure □Liver Disease □Kidney Disease □Hepatitis □Diabetes □Tuberculosis □Epilepsy or Seizure □BloodDisorders □Hormonal Disorder □Mental Illness □Anxiety □Fainting at the Dentist □Other_____

Dental History

What dental condition(s) concern you at present?	
Were X-rays taken at your last visit?	□No □Yes
Would you like to improve the appearance of your teeth?	□No □Yes
Do you floss your teeth daily?	□No □Yes
Have you had any complications or difficulties with previous dental treatment?	□No □Yes. Explain:
Select all that applies to your teeth and gum	□Bleeding Gums □Drifting of Teeth □Gum Ache □Receding Gums □Loose Teeth
Select all that applies to your teeth and jaw joint	□Grinding or Clenching Teeth □Clicking □Popping □Pain
How do you rate yourself as a dental patient?	□Calm □Slightly Anxious □Very Anxious

Consent *I hereby certify that the Medical and Dental Histories provided are accurate and complete to the best of my knowledge. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of anesthesia.*

Signature ***Date***