New Patient Form

324 - 58th Ave SE
Calgary, AB T2H 0P1
(403) 252-1444
info@westwinddental.ca

Personal Details

Date: ______________________________

Medical Alert: ______________________________

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Mstr. ☐ Miss. ☐ Dr.

First Name: ______________ Last Name: ______________

Preferred Name: ______________________________

Gender: ______________ Date of Birth: ______________

Address: ______________________________

City: __________ Province: __________ Date of Birth: __________

Cell #: __________ Home #: __________ Work #: __________

Preferred Phone: ☐ Cell ☐ Home ☐ Work

Email: ______________________________

Contact Method: ☐ Phone ☐ Email ☐ SMS ☐ Mail

Employer / School: ______________________________

Occupation: ______________________________

Are you available for short-notice appointments? ☐ Yes ☐ No

How did you hear about us? ☐ Social Media ☐ Newsletter ☐ Walk-In ☐ Referral ☐ Online

If referred, provide name of person/business: ______________________________

Emergency Contact Name: ______________________________

Emergency Contact Relation: ______________________________

Emergency Contact Phone #: ______________________________

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Personal Details Cont'd

Marital Status: ______________________________

Patient is a(n): ☐ Adult ☐ Child

Do you have dental insurance? ☐ Yes ☐ No
If yes, please complete the following.

Insurance Information

Name of Insured: ______________________ Date of Birth: ______________________

Insurance Company Name: ______________________________

Group / Plan #: ______________________ Certificate / Employee #: ______________________

Name of Employer: ______________________________

Are you the policy holder? ☐ Yes ☐ No

If not, please provide the following:

Name of Policy Holder: ______________________ Date of Birth: ______________________

Medical History

Are you presently under the care of a physician? ☐ Yes ☐ No

Physician Name: ______________________________

Physician's Phone #: ______________________________

Have you ever had any adverse or unusual reaction to any medication or injections? (e.g. penicillin, antibiotics, aspirin, codeine, local anesthetic (dental freezing)?

☐ Yes ☐ No

If yes, please specify:
____
____
____

Are you presently taking any kinds of medication?

☐ Yes ☐ No

If yes, please specify:
____
____
____

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Medical History Cont'd

Do you have a bleeding problem?

☐ Yes ☐ No

Are you pregnant?

☐ Yes ☐ No

Do you presently or have you ever had:

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Blood Disorder
☐ Cancer
☐ Diabetes
☐ Drug/Alcohol Dependency
☐ Epilepsy
☐ High/Low Blood Pressure
☐ Immune System Disorder (AIDS)
☐ Kidney Disease
☐ Lung Disease
☐ Migraine Headaches
☐ Rheumatic Fever
☐ Stroke/Heart Attack
☐ Thyroid Problems
☐ Tuberculosis
☐ Hepatitis

Have you ever had any illness not included above?

☐ Yes ☐ No

If yes, please specify:

____

____

____

Dental History

Do your gums bleed while brushing or flossing?

☐ Yes ☐ No

Are your teeth sensitive to hot or cold liquids or foods?

☐ Yes ☐ No

Do you feel pain in any of your teeth?

☐ Yes ☐ No

Do you have any sores or lumps in or near your mouth?

☐ Yes ☐ No

Have you ever had any head, neck, or jaw injuries?

☐ Yes ☐ No

Have you ever been advised to take antibiotics before dental appointments?

☐ Yes ☐ No

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Dental History Cont'd

Do you experience jaw pain?

☐ Yes ☐ No

Do you clench or grind your teeth?

☐ Yes ☐ No

Have you ever had any dental implant surgery?

☐ Yes ☐ No

Are you nervous about going to the dentist?

☐ Yes ☐ No

Have you had difficult extractions in the past?

☐ Yes ☐ No

Do you like your smile?

☐ Yes ☐ No

Do you have frequent headaches?

☐ Yes ☐ No

Do you feel that you have bad breath?

☐ Yes ☐ No

Do you smoke or chew tobacco?

☐ Yes ☐ No

Do you have an allergy to latex?

☐ Yes ☐ No

Do you wear dentures or partials?

☐ Yes ☐ No

Patient/Guardian Approval and Consent

I, the undersigned, certify that all the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I consent to the performing of dental and oral surgery procedures agreed necessary or advisable, including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with these procedures.

Patient (Parent / Guardian) Signature: ______________________

Date: ______________________

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Financial Agreements

For your convenience, we offer two options for paying your dental expenses.

A. I prefer to pay for my dental expenses at the time of my appointment. My insurance company will reimburse me directly.

B. I prefer West Wind Dental to bill my insurance company directly. Any balance remaining will be paid at the time of appointment. In some cases, the insurer does not provide a breakdown of payment so a credit card number is kept on file to apply the balance once we receive payment from the insurance company.

Please select your plan of choice.

☐ A ☐ B

Credit Card Number: ______________________ Expiry Date: ______________

Patient (Parent / Guardian) Signature: ______________________ Date: ______________

Cancellation Policy

Cancellations need to be made two business days prior to your appointment or a $75 fee will be applied.