Welcome to 16TH AVENUE DENTAL
STUDENT PATIENT REGISTRATION FORM

Please select your school: ☐SAIT ☐Mount Royal ☐ACAD ☐Bow Valley ☐U of C (Grad students ONLY)
☐Olds ☐Athabasca ☐U of AB (Undergrad) ☐U of AB (Grad)

Please select one: ☐Full-Time Student ☐Part-Time Student

***PLEASE NOTE:** If you are a Part-Time student, you may not be eligible for student coverage. If you are a U of C undergraduate student, your coverage will not pay for services provided at this dental office. All students must opt in for dental benefits and pay their institution for said coverage in order to have active insurance.*

***FOR U of C GRAD STUDENTS:** Please note the following recent changes to your dental benefits: An annual $20.00 deductible for single coverage or $40.00 deductible for family coverage which is collected by your dental provider, a reduced maximum of $800.00 per benefit year, and 70% basic coverage.*

Patient Name:_____
First Name Middle Initial Last Name Preferred Name

Date of Birth (MM/DD/YYYY):___/___/_____ Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐Child ☐Other

Address:_____
(If you live in residence, please include suite number) City Province Postal Code

Phone Numbers: (Cell)_____ (Home)_____ (Work)_____ Ext.____

Email Address:_____ The best way to reach you: ☐Cell ☐Home ☐Work ☐Email
Please print clearly (required for pre-authorizations)

Name and Phone Number of Emergency Contact: _____

Are you available to come for appointments on short-notice? If Yes, Availability: _____ ☐Yes ☐No

Preferred Appointment: *TIME* ☐Morning ☐Afternoon ☐Evening ☐Anytime
DAY OF WEEK ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Is another family member currently a patient here? If Yes, name of patient:_____ ☐Yes ☐No

INSURANCE INFORMATION

Are you covered under a student dental plan?: ☐Yes ☐No

Insurance Company:_____ Policy/Group #:_____ Student ID #: _____

In addition to university/college insurance, are you covered under any other insurance policies? ☐Yes ☐No

If YES, please provide the following information:

Full Name of Policy Holder:_____ Policy Holder's Date of Birth (MM/DD/YYYY):___/___/_____

Policy Holder's Occupation: _____ Policy Holder's Employer:

Insurance Company: _____ ID/Certificate #:_____ Policy/Group #:_____

Patient's relation to Policy Holder: ☐Self ☐Spouse ☐Common-Law Spouse ☐Child ☐F/T Student ☐Other

CONSENT

I, the *Patient/Parent/Guardian*, authorize for *16TH AVENUE DENTAL* to take x-rays, study models, photos, or any other diagnostic aids deemed appropriate by the Doctor in order to diagnose and develop a treatment plan for me. I also authorize the Doctor to perform any and all forms of treatment, medications, and therapy that may be indicated as mutually agreed upon. I understand that during a procedure, circumstances may dictate a change in technique or additional fees which I am responsible for. The most common being root canal therapy following routine restorative procedures, I authorize the Doctor to make any changes to my treatment plan as needed. The below signature also authorizes *16TH AVENUE DENTAL* to forward any patient information/records, which includes my Health History, x-rays and photos to any office which I may be referred to for further treatment. I understand that I am responsible for payment on the day of service for any fees not covered by my insurance, unless prior arrangements have been made. I understand that at least two business days (48 hrs) notice is needed if I cannot keep my appointment. Failure to provide this notice will result in a $60/hour missed appointment charge. If multiple appointments are missed, a non-refundable fee will be charged prior to booking another appointment.

I acknowledge that I have read and accept the conditions noted above.

Signature of Patient:_____ Date:_____
(Legal Guardian if patient is a minor/child)

DENTAL HISTORY

Patient Name:_____ Birth Date *(MM/DD/YYYY)*:____/____/_____ Sex: ☐M ☐F
Previous Dentist:_____ How long have you been a patient? _____ ☐months ☐years
Date of last dental exam *(MM/DD/YYYY)*: ____/____/_____ Date of last x-rays *(MM/DD/YYYY)*: ____/____/_____
I routinely see my dentist every ☐3 months ☐6 months ☐9 months ☐12 months ☐not routinely
What is your chief concern today?_____
How often do you brush?_____ How often do you floss?_____
Please rate your level of anxiety to dental treatment from 1 (Least) to 10 (Most):_____
Have you had an unfavorable dental experience? If Yes, describe:_____ ☐Yes ☐No
Have you ever had complications from past dental treatment? If Yes, describe:_____ ☐Yes ☐No
Have you ever had trouble getting numb or had any reactions to local anesthetic? ☐Yes ☐No
If Yes, please provide details:_____
How can we make your dental appointments more comfortable?_____
Are you unhappy with how your teeth look? If Yes, what would you change?_____ ☐Yes ☐No

Do you currently have or have had any of the following? ***(Please check all that apply to you):***

☐Cavities within past 3 years	☐Grinding/clenching habit	☐Bad taste/odor in the mouth
☐Sensitivity to sweets/hot/cold/biting	☐Pain in TMJ/locking jaw	☐Surgery in the mouth
☐Food catches between teeth	☐Periodontal treatment	☐Severe gagging
☐Injury to teeth/jaw	☐Orthodontic treatment	☐Cold sores/ulcers/swelling in mouth
☐Dental extraction	☐Gum recession	☐Denture
☐Loose teeth	☐Bleeding gums when flossing/brushing	☐Sleep apnea/snoring

Please provide details of any positive answers above:_____

MEDICAL HISTORY

Date of last physical exam:_____ Physician/Specialty:_____ Tel:_____
How would you rate your general health? ☐Excellent ☐Good ☐Fair ☐Poor
Do you smoke tobacco? If Yes, what type and how often?_____ ☐Yes ☐No
Do you have or have you had, any of the following medical conditions? ***(If yes, please check)***:

☐Abnormal bruising or bleeding	☐Circulatory problems	☐Hemophilia	☐Respiratory disease
☐Arthritis, Rheumatism	☐Congestive heart failure	☐Hepatitis A, B or C	☐Rheumatic fever/Rheumatic heart disease
☐Artificial joints	☐Cortisone treatments/steroids	☐Heart murmur/prolapsed valve	
☐Asthma, Sinus Problems	☐Diabetes (Type: _____)	☐High/Low blood pressure	☐Sexually transmitted disease
☐Autoimmune disease	☐Eating disorder	☐Jaundice/Liver disease	☐Shortness of breath
☐AIDS/HIV positive	☐Epilepsy/Seizures	☐Kidney disease	☐Skin disease or rash
☐Back problems	☐Eye disorder/Glaucoma	☐Nervous disorders	☐Stroke
☐Blood disorders (eg. Anemia)	☐Fainting	☐Pacemaker (Year placed:_____)	☐Thyroid disease
☐Cancer (Type: _____)	☐Headaches/Migraines	☐Prosthetic Heart Valve	☐Tuberculosis
☐Chemotherapy	☐Hearing problem	☐Psychiatric care	☐Tumors, cysts or growths
☐Cholesterol	☐Heart disease (describe below)	☐Radiation treatment	☐Ulcer/Digestive disorder

Please provide details of medical condition: _____

_____

Allergies: ☐NONE ☐Aspirin ☐Codeine ☐Latex ☐Local Anesthetic ☐Penicillin ☐Sulfa ☐Other:
Are you currently or have you ever taken bisphosphonates? (eg. Fosamax, Zometa) ☐Yes ☐No
Are you currently taking any blood thinners? (eg. Aspirin, Warfarin, Plavix, Heparin, Eliquis, Pradaxa, Xarelto) ☐Yes ☐No
Are you required to take antibiotics prior to dental treatment? If Yes, Reason:_____ ☐Yes ☐No
****LIST ALL MEDICATIONS, SUPPLEMENTS, VITAMINS, RECREATIONAL DRUGS AND/OR HERBS YOU ARE CURRENTLY TAKING:**

DRUG	PURPOSE	DRUG	PURPOSE

*****Please advise us in the future of any changes in your medical history or any new medications you may be taking***
Have you had a serious illness, operation or been hospitalized in the last 5 years? ☐Yes ☐No
If Yes, what was the illness or problem?_____
Do you have any surgeries planned in the future? If Yes, describe:_____ ☐Yes ☐No
[WOMEN ONLY] Are you: ☐Pregnant (Expected Delivery Date:_____) ☐Nursing ☐Taking birth control pills

Signature of Patient/Parent/Guardian:_____ Date:_____ Doctor's Initials:_____