Blue Quill dental centre

780.436.6971
294 Saddleback Rd. Edmonton, AB. T6J 4R7
www.bluequilldental.com

Welcome! To serve you as best we can, please fill out your information below. All information will be strictly confidential.

Patient Information

First Name, MI *Last Name*

Patient Name: _____ Phone number: Home/cell _____ Work _____

Date of Birth (M/D/Y): _____ Gender: ◯ Male ◯ Female

Address: _____ City, Province: _____

Postal Code: _____ Email: _____

Occupation: _____ Employer: _____

Emergency Contact and Phone: _____ Relationship: _____

Preferences

Preferred Appointment Times *(Check all that apply)*:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8am – 12pm	☐	☐	☐	☐	☐	☐
12pm – 3pm	☐	☐	☐	☐	☐	☐
3pm – 6pm	☐	☐		☐		

Benefits Information

(If insurance is under your name)

Benefits Provider Company Name: _____

Group / Policy Number: _____ Certificate / Subscriber ID: _____

Alberta Health Care Number: _____

Additional Benefits (If applicable, or if insurance is under another name)

Benefits Provider Company Name: _____

Group / Policy Number: _____ Certificate / Subscriber ID: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

How Did You Hear About Us?

☐ Live Nearby ☐ Signage ☐ Facebook / Social Media

☐ Google / Online ☐ Referral *(let us know who to thank)* ☐ Other (specify):

_____ _____

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Medical History

Family Doctor: _____ Doctor's Phone Number: _____

Last Medical Check-Up: _____

Please circle or check which of the following you have had in the past, or have at present.

Nervous System
- ☐ Chronic Headaches
- ☐ Convulsions / Epilepsy
- ☐ Dizziness / Fainting
- ☐ Depression / Anxiety
- ☐ Trigeminal Neuralgia
- ☐ Chronic Pain

Respiratory
- ☐ Asthma / Hay Fever
- ☐ Sinus Problems
- ☐ Difficulty Breathing
- ☐ COPD / Lung Disease

Bones / Muscles
- ☐ Arthritis / Rheumatism
- ☐ Artificial Joints / Limbs
- ☐ Osteoporosis

Date of Any Joint Replacements:
_____

Endocrine
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Thyroid / Goiter

Heart / Circulatory
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Chest Pain / Discomfort
- ☐ Heart Attack / Stroke / TIA
- ☐ Pacemaker

Heart / Circulatory
- ☐ Shortness of Breath
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve/Stent
- ☐ Endocarditis

Allergies
- ☐ Local Anesthetics
- ☐ Latex Sensitivity
- ☐ Penicillin
- ☐ Aspirin
- ☐ Codeine

Blood
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Bleeding Disorder
- ☐ Excessive Bleeding
- ☐ Prolonged Healing

GI System
- ☐ Hepatitis *(Specify type)* ____
- ☐ Liver Disease / Jaundice
- ☐ Ulcers
- ☐ Kidney Trouble

Additional Allergies: _____
_____

Immune System
- ☐ Radiation / Chemotherapy
- ☐ AIDS / HIV
- ☐ Cancer
- ☐ Autoimmune Disorder

Have you ever been hospitalized or had a serious illness? ◯ **Yes** ◯ **No**

If yes, please specify: _____

Are you being treated for any other medical condition not listed? ◯ **Yes** ◯ **No**

If yes, please specify: _____
_____

Are you taking any medications, non-prescription drugs, or herbal supplements? ◯ **Yes** ◯ **No**

If yes, please list: _____

_____

Do you use tobacco products? *If yes, what and how much/often?* _____

◯ Yes ◯ No

Do you use any recreational drugs? *If yes, what and how much/often?* _____

◯ Yes ◯ No

FEMALE ONLY: Are you pregnant? ◯ **Yes** ◯ **No** *If yes, how many months?* _____

Are you breastfeeding? ◯ **Yes** ◯ **No**

Are there any diseases or medical problems that run in your family?

If yes, please specify: _____

Please indicate anything else we should know about your health:

_____

_____

Dental History

Last Dental Visit: _____

Last Dental X-Ray(s): _____

How often do you brush your teeth? _____

How often do you use dental floss? _____

Do you experience or have *(please circle or check)*:

Have you ever had local anaesthetic (freezing)?

◯ Yes ◯ No

Were there any complications?

◯ Yes ◯ No

If so, please specify:

_____

- ☐ Bleeding / Soft Gums
- ☐ Unpleasant Taste / Bad Breath
- ☐ Mouth Blisters / Lumps
- ☐ Orthodontics / Braces
- ☐ Clicking / Popping Jaw
- ☐ Jaw Accidents / Injuries
- ☐ Misaligned teeth
- ☐ Teeth Sensitivity (Hot / Cold)
- ☐ Facial Pain
- ☐ Difficulty Chewing / Swallowing
- ☐ Food Catching In Between Teeth
- ☐ Clenching / Grinding Teeth
- ☐ Shifting Teeth
- ☐ Stained Teeth

On a scale of 1 to 10, how satisfied are you with your smile?

◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Anything Specific?

_____

_____

I understand the above information is necessary to provide me with the dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to Blue Quill Dental Centre. I will notify Blue Quill Dental Centre of any change in my health or medication.

Signature: _____ Printed name: _____ Date: _____

Patients under the age of 18 must have the legal parent or guardian sign