COCHRANE DENTAL CENTRE
Dr. David B. Sawka & Associates

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date _____

Your Name: _____
Last First Initial

I prefer to be called: _____ ❑ Male ❑ Female

Birthday _____/_____/_____ Age _____
Month Day Year

Home Address _____

_____
City Postal Code

Home Phone #: _____ **Cell Phone #:** _____

Work Phone #: _____ Ext: _____

E-mail: _____

Employer: _____

Occupation _____

When and where are the best times to reach you? _____

_____

Who may we THANK for referring you? _____

Other family members seen by us: _____

_____

2 About Your Spouse

Name: _____
Last First Initial

Employer: _____

Work Phone #: _____ Ext: _____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Their Name: _____ Relation: _____

Work Ph #: _____ Home Ph #: _____

3 Your Dental Insurance

Primary Dental Insurance

Insured's Name: _____
Last First Initial

Birthdate of Insured: _____/_____/_____
Month Day Year

Relation: _____

Employer: _____

Insurance Co. Name: _____

Group # _____ Div. #: _____

Certificate #:: _____

Coverage Basic%_____ Major %_____ Yearly Max: _____

What restrictions do you have on your dental insurance?

_____

_____

eg. How many units of scaling are covered?
How often does your plan cover a dental examination?

Secondary Dental Insurance

Insured's Name: _____
Last First Initial

Birthdate of Insured: _____/_____/_____
Month Day Year

Relation: _____

Employer: _____

Insurance Co. Name: _____

Group # _____ Div. #: _____

Certificate #:: _____

Coverage Basic%_____ Major %_____ Yearly Max: _____

What restrictions do you have on your dental insurance?

_____

_____

eg. How many units of scaling are covered?
How often does your plan cover a dental examination?

Thank you for filling out this form completely. It enables us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help! Our office is committed to exceeding the standards of infection control mandated by OHSA, the CDA and the ADA.

COCHRANE DENTAL CENTRE

Dr. David B. Sawka

Please tell us what you require for today's visit:

- ❑ Full mouth examination and treatment plan.
- ❑ Specific problem only.

Are you having any pain or discomfort at this time? ❑ Yes ❑ No

Have you ever had a complication with past dental work? ❑ Yes ❑ No

On a scale of 1 - 10 (1 being not nervous at all, 10 extremely nervous to just sit in the chair).

please rate your comfort with dental appointments _____.

What can we do to make your visit more comfortable? _____

Who was your previous dentist?_____ Approximate date of last appointment _____

Please check if any of the following apply to you:

Teeth that are sensitive to heat or cold	❑	Food getting stuck between your teeth	❑
Teeth sensitive to sweets	❑	Gums that bleed or feel tender when you brush or floss	❑
Teeth sensitive to biting pressure	❑	Frequent cold sores, canker sores or any other mouth sores	❑
Broken fillings or rough edges on teeth	❑	Did you ever experience a skin reaction to jewellery or watches	❑

Are you aware of grinding or clenching your teeth?	Y	N
Does chewing gum bother your jaw?	Y	N
Are you aware of any popping, clicking or grinding noises when you move your jaw?	Y	N
Do you suffer from chronic headaches or chronic pain in the neck or back?	Y	N
Have you ever had injury to the chin, face or head or been in a motor vehicle accident?	Y	N

Do you think your teeth are worth keeping for a lifetime?	Y	N
If you could safely whiten your teeth, would you be interested?	Y	N

Is there anything you would like to change about your smile?

_____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____ _____

Signature of Patient Date

I verbally reviewed the medical and dental information above with the patient herein. _____

NAME: _____ DATE: _____

WELCOME TO COCHRANE DENTAL CENTRE

NAME: _____ PARENT/GUARDIAN: _____
ADDRESS: _____ BIRTHDAY: _____ ☐M ☐F
CITY: _____ POSTAL CODE: _____
HOME PHONE: _____ WORK PHONE: _____
CELL PHONE: _____ EMERGENGY CONTACT: _____

PLEASE PROVIDE CONTACT INFORMATION FOR YOUR FAMILY PHYSICIAN:

NAME: _____ PHONE: _____

MEDICAL HISTORY FORM:

Condition		Details of Specified Condition	Notes (office use only)
Anaemia	Yes☐ No☐		
Angina	Yes☐ No☐		
Anorexia/Bulimia	Yes☐ No☐		
Artificial Joints	Yes☐ No☐		
Asthma	Yes☐ No☐		
Bleeding Disorder	Yes☐ No☐		
Cancer	Yes☐ No☐		
Chronic Pain	Yes☐ No☐		
Cortisone/Steroid Treatment	Yes☐ No☐		
Depression/Anxiety	Yes☐ No☐		
Diabetes (Type I/II)	Yes☐ No☐		
Drug/Alcohol Abuse	Yes☐ No☐		
Emphysema	Yes☐ No☐		
Epilepsy/Seizures	Yes☐ No☐		
Fainting	Yes☐ No☐		
Glaucoma	Yes☐ No☐		
Head/Neck Radiotherapy	Yes☐ No☐		
Heart Attack/Stroke	Yes☐ No☐		
Heart Defect/Valve	Yes☐ No☐		
Heart Murmur	Yes☐ No☐		
Hepatitis (A,B or C)	Yes☐ No☐		
HIV/Immunocompromised	Yes☐ No☐		
Hypoglycemia	Yes☐ No☐		
Kidney Disease	Yes☐ No☐		
Leukemia	Yes☐ No☐		
Liver Disease	Yes☐ No☐		
Osteoporosis	Yes☐ No☐		
Pacemaker	Yes☐ No☐		
Rheumatic/Scarlet Fever	Yes☐ No☐		
Rheumatoid Disease	Yes☐ No☐		
Sinus Problems	Yes☐ No☐		
Thyroid Disease	Yes☐ No☐		
Tuberculosis	Yes☐ No☐		
Ulcers/Colitis	Yes☐ No☐		
Venereal Disease	Yes☐ No☐		

NAME: _____ DATE: _____

ALLERGIES

Are you **allergic** to the following?

Medication		Details/Date	Medication		Details/Date
Penicillin Antibiotics (including amoxicillin)	Yes☐ No☐		Nitrous Oxide	Yes☐ No☐	
Latex (dental gloves)	Yes☐ No☐		Local Anesthetics	Yes☐ No☐	
Codeine	Yes☐ No☐		Sulpha Drugs	Yes☐ No☐	
Erythromycin	Yes☐ No☐		Nickel	Yes☐ No☐	
Asprin	Yes☐ No☐		Iodine	Yes☐ No☐	

MEDICATIONS

Please list **all medications** you are taking below:

Medication	Date	Dosage	Condition Treated/Further Details

LIFESTYLE

Do you **smoke**: Yes☐ No☐
If so *how much*: _____

Do you chew **tobacco**: Yes☐ No☐
If so *how often*: _____
Where in the mouth do you place it? _____

FOR WOMEN ONLY

Are you pregnant? Yes☐ No☐
Are you nursing? Yes☐ No☐

Due Date _____
Until? (estimated) _____

SIGNATURE

I hereby certify that the information disclosed in this medical history form is accurate to my knowledge

Name: _____ Signature: _____

Dr. David B. Sawka & Associates

WELCOME TO OUR PRACTICE!

Thank you for selecting us as your personal dental team. We are very proud of our knowledgeable, well trained, and caring dental team. You will find us dedicated to maintaining optimum oral health.

Please take time to familiarize yourself with some of our office procedures and policies.

- No charge will be made for rescheduling an appointment, providing 24 hours working notice is given, otherwise a charge may be incurred. Once an appointment has been made, please remember this time has been reserved specifically for you.
- Dental insurance is a contract between you and your insurance company. As a courtesy, we will prepare and submit dental claims on your behalf. Our office does not accept insurance assignment of benefits. We require full payment of services at each visit, and your insurance will send the payment to you directly. Please be aware that it is your responsibility to know your dental plan and any changes that may occur from time to time.
- All accounts are to be paid in full at each appointment, unless written financial arrangements are signed in advance of your treatment. Please discuss payment options and fees with one of our staff, and they would be pleased to work with you to make the required arrangements. For such extended financial arrangements we require an initial deposit before treatment is started and post dated cheque, Visa/MasterCard payments to be left for the balance.
- For your convenience, we accept the following forms of payment: cash, Visa, MasterCard, direct payment (Interac), cheque, post dated Visa, MasterCard, or cheque.

YOUR FINANCIAL CONSENT

The patient/or guardian agrees to be fully responsible for total payment of procedures performed in this office, including any treatment not a covered benefit of any dental insurance the patient may have.

I certify I have read and understand the above.

Date:_____

Patient/Guardian Signature:

_____

FINANCE

Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option that you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

❑ Cash ❑ Debit

❑ Credit Card ❑ Visa ❑ MasterCard

Card#_____

Expiry Date _____ Signature_____

#10 - 402 RAILWAY STREET COCHRANE, AB T4C 2B6 (403) 932-3031

Dr. David Sawka

Dental Office Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses (collectively referred to as "Contact Information"). Contact Information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment.
- To send patients informational material about our dental practice.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. (Collectively referred to as "Medical Information") Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other dentists and dental specialists if the patient has been referred by us to the other dentist or dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal information as set out above.

_____	_____	_____
D*ate*	*Print name*	*Signature*