DIMENSION DENTISTRY
Complete Family and Cosmetic Dental Care

Dr. Brent Fairbanks Dr. Troy Michelson Dr. Mark Fairbanks
#302, 51 Sunpark Dr. SE, Calgary AB T2X 3V4
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Contact Information

First Name: _____Last Name: _____

DOB (D/M/Y):_____/_____/_____

Contact Number: H (_____) _____ W (_____) _____ C (_____) _____

Street Address:_____ City: _____

Province: _____Postal Code: _____

Email Address: _____

Emergency Contact: _____ Emergency Number: (_____) _____

Dental Profile

Date of Last Dental Visit:
_____

Date of Last X-Rays:
_____

Name of previous Dental Office/ Dentist:
_____

When was your last dental hygiene visit?
_____

What has prompted your visit to our office today?
_____

Do your gums bleed when you floss or brush? Y □ N □

Do you wear dentures or partial dentures Y □ N □
If yes, are you happy with how your denture fits? Y □ N □

Are your teeth sensitive to cold, hot or pressure? Y □ N □
If yes, please specify: _____

Do you snore? Y □ N □
If yes, have you been tested for sleep apnea? Y □ N □

Do you grind or clench your teeth? Y □ N □

Does food or floss catch between your teeth? Y □ N □

Is your mouth dry? Y □ N □

Have you had any periodontal (gum) treatments? Y □ N □
If yes, please specify:
_____

Have you ever had orthodontic (braces) treatment? Y □ N □

This is to certify that I, undersigned, consent to the performing of the dental and/or oral surgery procedure agreed necessary or advisable, including oral anesthetic sedation as indicated, and I will assume responsibility for all fees associated with these procedures.

Signature _____ Date: _____

Medical Profile

Name of Medical Physician:
_____

Medical Physician Phone (if known): (_____) _____

Date of Last Physical Exam: _____

To the best of your knowledge, are you in good health? Y □ N □

Describe any notable health changes in the past 2 years.
_____

Are you presently under the care of a specialist? Y □ N □
If yes, what is the condition being treated?
_____

Any serious illnesses, surgeries or hospitalization? Y □ N □
If yes, what was the illness, surgery or hospitalization and when?
_____

Are you taking any medications or drugs or supplements? Y □ N □
If yes, what are you taking and why?
_____

Have antibiotics ever been suggested prior to dentistry? Y □ N □

Are you allergic to/had adverse reactions to any drug/medication?
Y □ N □
If yes, what drug & what was your reaction? _____
_____

Have you ever had an adverse reaction to local or general anesthetic?
Y □ N □
If so, please specify? _____

Do you use tobacco (smoking/smokeless tobacco/bidis)?
Y □ N □
If yes, how interested are you in stopping?
Very_____ Somewhat _____ Not Interested _____

If female, are you pregnant? Y □ N □ Possibly □

Please check if you have ever been treated for:

□ Heart Problems or Stroke
□ Tuberculosis or Lung Disease
□ HIV/AIDS
□ Asthma
□ Arthritis or Rheumatism
□ Sexually Transmitted Disease
□ Rheumatic Fever
□ Psychiatric or Mental Disorder
□ Thyroid Disease
□ Cancer
□ Kidney Disease
□ Liver Disease
□ Epilepsy or Seizures
□ Osteoporosis / Bone Disorder
□ Glaucoma
□ Pacemaker
□ Severe Headaches or Migraines
□ G6PD Enzyme Deficiency
□ Joint Replacement
□ Diabetes
□ Hyper or Hypo Glycemic
□ Hepatitis
□ Jaundice
□ Head / Face Injury
□ High or Low Blood Pressure
□ Nervous Disorder/Nervousness
□ Anemia
□ Artificial Heart Valve
□ Fainting Spells
□ Chest Pains
□ Endocrine Problems
□ Gastrointestinal Problems
□ Hearing Disorder
□ Scarlet Fever
□ Sinus Problems
□ Eating Disorder
□ Allergy to Chlorhexidine or Photosensitizing Medication

Is there anything that the dentist should know regarding your medical status or health that has not been mentioned? _____
_____

The team at Dimension Dentistry strives help people improve the quality of their lives by providing the highest standard of dental care possible, including uncompromising personalized service with meticulous attention to the individual needs of our patients, their families, with a commitment to caring and respecting every person we have the privilege to serve.

Please check what is important to you as our valuable patient:

□ Direct Billing □ Open Weekends & Evenings □ Comfort Menu □ Sedation Services □ Sterilization Practices

What or who prompted you to choose Dimension Dentistry: _____

Insurance Information

Name of Primary Policy Holder	**Date of Birth** **DD/MM/YY**	**Primary insurance Company**	**Group Policy Number**	**ID of Certificate Number**
Patient's relationship to policy holder: Self ☐ Spouse ☐ Child ☐ Other ☐				
Name of Secondary Policy Holder	**Date of Birth** **DD/MM/YY**	**Secondary insurance Company**	**Group Policy Number**	**ID of Certificate Number**
Patient's relationship to policy holder: Self ☐ Spouse ☐ Child ☐ Other ☐				

Payment Options

Dimension Dentistry is pleased to offer 2 payment options for your convenience. Please let us know which you would prefer.

☐ Option 1: Payment is due in full at the time of service. We accept Visa, MasterCard, Debit, Cash and American Express. Your payment will be processed and we will submit your dental claim to your insurance carrier, on your behalf. Your insurance carrier will reimburse you via your chosen payment method (direct deposit or cheque).

☐ Option 2: Assignment of Benefits: Your insurance carrier must allow 'Assignment of Benefits.' We will submit your dental claim to your insurance carrier on your behalf, and you will be responsible for the remaining portion not covered through your insurance. A valid credit card MUST remain on file. This includes dual insurance holders. It is your responsibility to notify Dimension Dentistry of any changes which affect your credit card account. Your account must remain in 'good standing' and any outstanding/uncollectable balance for more than 60 days will no longer be considered eligible for Direct Billing services offered. I, _____ authorize Dimension Dentistry to keep my signature on file and to issue a credit or debit memo to my credit card account for any over and under payment once my insurance portion has been received. I will be notified by telephone or mail if my account is charged or credited within an excess of $200. I give my permission for any claim not paid by my insurance company for myself and any family member listed below to be automatically charged to my credit card. A receipt for this transaction will be mailed with a paid statement.

If you do not wish to leave a credit card number on file, Option 1 is your choice.

Signature: _____

(Option 2) Family members to include for Direct Billing:

_____ _____

_____ _____

Appointment Agreement

While visiting our team at Dimension Dentistry, recommended treatment is often of an urgent nature. The sooner we can diagnose and treat dental disease the better it will be for your oral health. In addition, we understand that at times dental emergencies may arise that require immediate attention. Whatever your need may be, we promise we will do our best to see you as soon as possible.

Trying to accommodate every patient's individual needs can be difficult. A scheduled appointment is a commitment of time between each of us. When appointments are cancelled, time that was reserved will be permanently lost. Cancelled appointments make it very difficult to provide timely service to our patients.

Please indicate how you would like to be advised of your next scheduled appointment: □ Email □ Phone call

As a highly valued patient we trust that when an appointment is made to suite your schedule, you will make every effort to keep that commitment. We do respect your time, ours and the other patients in our office. Should a conflict arise, please provide us with two business days' notice. We recognize that as our patients keep this commitment, we are more able to provide for their dental needs.

Patient Signature: _____ Date: _____