Jasper Avenue Dental
Suite 201, 10503 Jasper Avenue, Edmonton, AB, T5J 1Z4
(780) 780-423-1930 www.2th.com

Dental Insurance Information

Primary Insurance

Name of Policy Holder: _____ Policy Holders Date of Birth: _____

Insurance Company: _____ Group/Policy #: _____

Certificate/ID #: _____

Patient's relationship to insured:

○ Self ○ Spouse ○ Child ○ Other _____

Secondary Insurance

Name of Policy Holder: _____ Policy Holders Date of Birth: _____

Insurance Company: _____ Group/Policy #: _____

Certificate/ID #: _____

Patient's relationship to insured:

○ Self ○ Spouse ○ Child ○ Other _____

Consent to Submit Claims Electronically

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revokes same.

Signature: _____ Date: _____

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Dental History

Date of last Dental visit: _____

Name of Dentist or Office: _____

Have you ever had periodontal (gum) treatment? ○ Yes ○ No

If Yes, When? _____

Have you had previous orthodontic treatment (braces)? ○ Yes ○ No

If Yes, When? _____

Do you have / wear a removable partial denture? ○ Yes ○ No

Have you had root canal therapy? ○ Yes ○ No

Have you had complications associated with previous dental treatment? ○ Yes ○ No

Please specify: _____

Are you aware of clenching, grinding, cheek biting, lip biting, mouth breathing, other? ○ Yes ○ No

Do you wake up with an awareness / discomfort of your teeth or jaw? ○ Yes ○ No

Have you had an injury to your face or jaw? ○ Yes ○ No

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Are you aware of any grinding, popping, clicking, or unusual sensations from your jaw? ○ Yes ○ No

What is the reason for your visit today? _____

Medical History

Date of last visit to a physician: _____ Reason: _____

Name of primary care physician: _____

1. Have you ever had any of the following diseases or conditions?

- ☐ Jaundice
- ☐ Tuberculosis
- ☐ Pacemaker
- ☐ Epilepsy
- ☐ Blood disorder
- ☐ Asthma
- ☐ Arthritis
- ☐ HIV Positive
- ☐ Environmental / Meta / food allergies
- ☐ Alzheimer's
- ☐ Hepatitis
- ☐ Heart trouble
- ☐ Stroke
- ☐ Diabetes
- ☐ Emphysema
- ☐ Cancer
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Dementia
- ☐ Thyroid

2. Do you have high blood pressure? ☐ Yes ☐ No
If Yes, is it controlled? ☐ Yes ☐ No

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3. Do you bleed for a long time when cut? ☐ Yes ☐ No

4. Do you bruise easily? ☐ Yes ☐ No

5. Are you ever short of breath on mild exertion? ☐ Yes ☐ No

6. Are you in recovery from drug or alcohol dependence? ☐ Yes ☐ No
If yes, when is your anniversary date: _____

7. Do you have a prosthetic or artificial limb? ☐ Yes ☐ No
If yes, please explain: _____

8. Do you smoke? ☐ Yes ☐ No

9. Please check any you have ever had an allergic reaction to:

☐ Aspirin
☐ Penicillin
☐ Antibiotics
☐ Codeine
☐ Other: _____
☐ Ibuprofen
☐ Sulfa
☐ Sedatives
☐ Latex

10. Are you presently taking any prescriptions or over the counter medications? ☐ Yes ☐ No
If yes, please specify:

Name of Drug	How is drug taken	Frequency	Duration on the drug	Are Refills issued

11. Have you ever reacted to dental anaesthetic? ☐ Yes ☐ No

12. Do you have a tendency to faint? ☐ Yes ☐ No

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13. What is your current Weight: _____(lbs/kg) Height: _____(ft.in/cm)

14. Are you pregnant at the present time? ☐ Yes ☐ No
If yes, what is your due date? _____

15. Are you taking oral contraceptives? ☐ Yes ☐ No

16. Do you have or have you ever been treated for depression, anxiety or any psychiatric condition?
☐ Yes ☐ No
If yes, please explain: _____

Signature: _____ Date: _____

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Smile Evaluation

Do you like the appearance of your teeth: your smile?

☐ Yes ☐ No

If not, please explain: _____

Are your teeth all in alignment (straight)?

☐ Yes ☐ No

If not, please explain: _____

Do you have spaces that you don't like?

☐ Yes ☐ No

If yes, please explain: _____

Do you like the color of your teeth?

☐ Yes ☐ No

If not, please explain: _____

Do you like the shape of your teeth?

☐ Yes ☐ No

If not, please explain: _____

Are there old fillings or dental work you don't like looking at?

☐ Yes ☐ No

If yes, please explain: _____

What would you like to change the most in the appearance of your teeth?

_____

Response Date: _____