Northland Village Dental Centre

#2003, 5111 Northland Drive NW Calgary, AB T2L 2J8

Phone: 403-255-6688 Fax: 403-202-8686

Welcome to our practice!

On behalf of our entire team, we wish to welcome you to our comprehensive dental practice. We are pleased you have chosen us to provide you with all of your dental needs. At Northland Village Dental Centre, we are committed to delivering the best patient experience possible. We hope that you will be a member of the Northland Village Dental Centre family for years to come.

For your convenience, we have enclosed a new patient registration form. These forms help us provide the best possible care for you. Please be prepared for your appointment by printing and completing the new patient registration form. If you have dental insurance, be sure to provide all requested information to assist us in the benefit verification process. Payment is expected at the time of the first visit. If you are covered by insurance, we will expect a payment of your portion at the time of service unless prior arrangements are made. As a courtesy, we will file claims on your behalf with your dental insurance company. If you have any questions about finances, please feel free to ask us at any time.

Please bring the enclosed forms (completed) with you to your scheduled appointment.

We ask that you make every effort to keep your appointment. Missing an appointment disrupts proper sequencing of care and delays completion of your treatment. If you need to reschedule your appointment, please call us at least 2 business days ahead prior to your visit.

As always, any questions or suggestions you may have will be most welcomed. You are special to us, and we will strive to uphold the trust and confidence you have expressed in us by becoming one of our patients.

We look forward to meeting you and serving your dental needs now and in the future.

Sincerely,

Dr. Lu and Associates
Northland Village Dental Centre

Patient Information

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Name: _____ Date of Birth: _____/_____/_____
Last First Initial

Male☐ Female☐ Age _____ Single ☐ Married☐ Separated☐ Divorced ☐Widowed ☐

Address: _____
Street Apt.# City Province Postal Code

Phone: Home: _____ Cell: _____ Work: _____

E-mail Address: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Tel: _____

Family Doctor: _____ Tel: _____

How Did You Hear About Our Office? Patient Referral ☐Yellow Pages☐ Website ☐Walk/Drive By☐ Other ☐

Responsible Party

Name: _____ Relationship to Patient: _____
Last First Initial

Date of Birth: _____/_____/_____

Address: _____
Street Apt.# City Province Postal Code

Phone: Home: _____ Cell: _____ Work: _____

Is this Person Currently a Patient in our Office? Yes ☐ No☐

Insurance Information

Patient's relationship to the Insured ☐ Self ☐ Spouse ☐Child☐ Other: _____

Name of the Insured: _____ Date of Birth: _____/_____/_____

Employer: _____ Work: _____

Insurance Company: _____ Start Day: _____

Policy/Plan/Group #: _____ Certificate/ID #: _____

Yearly Maximum: $ _____ Basic _____% Major _____% Deductible $ _____ Single _____ Family _____

Patient's relationship to the Insured ☐ Self☐ Spouse ☐Child ☐Other: _____

Name of the Insured: _____ Date of Birth: _____/_____/_____

Employer: _____ Work: _____

Insurance Company: _____ Start Day: _____

Policy/Plan/Group #: _____ Certificate/ID #: _____

Yearly Maximum: $ _____ Basic _____% Major _____% Deductible $ _____ Single _____ Family _____

Medical History

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Yes☐ No ☐ Are you presently under the care of a physician?
Yes☐ No ☐ Have you had any serious illnesses, operations, or hospitalization: If YES, please give dates and reason: _____
Yes☐ No ☐ Are you currently taking any medication? If YES, please list:_____
Yes☐ No ☐ Have you ever taken Fen-Phen or Redux (Anti-obesity medication)?
Yes☐ No ☐ Do you bruise easily or have prolonged bleeding?
Yes☐ No ☐ Do you smoke or chew tobacco? How much per day? _____
Yes☐ No ☐ Have you ever fainted, had shortness of breath or chest pains?
Yes☐ No ☐ Any fever or chills within the last 24 hours?
Yes☐ No ☐ Any recent exposure to infectious disease? (e.g., Measles, Chicken Pox or Tuberculosis)
Yes☐ No ☐ Any history of joint prosthesis procedures in the past 2 years?
Yes☐ No ☐ Any family history of Prion Disease, or symptoms that may be indicative of CJD, such as sudden onset of dementia?
Yes☐ No ☐ Recent travel? Where to? _____
Immunization History _____

Women Only: Are you pregnant? Yes☐ No☐ Nursing? Yes☐ No☐ Taking birth control pills? Yes☐ No☐

Allergies: Aspirin ☐ Barbiturates (sleeping pills)☐ Codeine☐ Sulfa Drugs☐ Iodine☐ Latex☐ Local Anesthetic (e.g. Novocain) ☐ Antibiotics (e.g. Penicillin)☐
Others: _____

Do You Have or Have You Ever Had the Following:

☐ Anemia
☐ Angina
☐ Anorexia
☐ Artificial Heart Valves
☐ Arthritis /Rheumatism
☐ Artificial Replacements
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Bronchitis
☐ Bulemia
☐ Cancer
☐ Chest Pains
☐ Chronic Diarrhea
☐ Chronic Fatigue
☐ Circulation Problems
☐ Cough, Persistent
☐ Cortisone Treatments
☐ Diabetes
☐ Depression/Anxiety
☐ Emphysema
☐ Epilepsy
☐ Fainting/Dizziness
☐ Frequently Tired
☐ Glaucoma
☐ Hay Fever
☐ Head/Neck Injuries
☐ Heart Attack/Disease
☐ Heart Murmurs
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis Type: _____
☐ Herpes
☐ High Blood Pressure
☐ HIV/AIDS
☐ Hypertension
☐ Hypoglycemia
☐ Jaundice
☐ Kidney Disease
☐ Leukemia
☐ Liver Disease
☐ Mental Disorder
☐ Mitral Valve Prolepses
☐ Organ Transplant
☐ Pacemaker
☐ Radiation Therapy
☐ Recent Weight Loss
☐ Respiratory Disease
☐ Rheumatic/Scarlet Fever
☐ Sexually Transmitted Disease
☐ Shortness of Breath
☐ Sinus Problems
☐ Stroke
☐ Swollen Ankles
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ Others _____

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Dental History

1. What is the reason for today's visit?
   Emergency ☐ Examination ☐ Other _____
2. How frequently do you see a dentist?
   3-6 months ☐ Annually ☐ Other _____
3. Date of last dental cleaning: _____ Last x-rays? _____ Previous Dentist _____
4. How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____
5. Are your teeth sensitive to: Hot ☐ Cold ☐ Sweets ☐ Other _____
6. Do your gums bleed when: Brushing ☐ Flossing ☐ Never ☐
7. Do your gums feel swollen or tender?
8. Does your breath concern you?
9. Do you have any jaw/joint problems?
10. Do you grind or clench your teeth?
11. Do you get frequent headaches?
12. Does food get caught between your teeth?
13. Have you ever had a problem with local anesthetic (freezing)?
14. Have you ever had any problems with previous dental treatments?
    Specify: _____
15. Is there anything else that we should know about your health?
    If YES, please explain: _____
16. Are you satisfied with the appearance of your teeth?
    If NO, please describe: _____
17. Are you fearful of dental treatments?
    What triggers your fear? Needles ☐ Smells ☐ Sounds ☐ Fear of Pain ☐

Consent for Treatment

I hereby certify that the information in the medical and dental histories is accurate and complete to the best of my knowledge. I authorize the release of medical information from my medical doctor or health care provider as is required by this dental office. I consent to the dental procedures agreed to be necessary or advisable for myself and my child, including the use of local anesthetic, or other drugs as indicated. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered for both myself and my dependents.

_____ _____ _____

Patient Name | Patient/Parent Signature | Date

As per the new Anti-Spam Legislation, I consent to receive electronic messages from Northland Village Dental Centre for appointment reminders/confirmations and all correspondence deemed necessary. I am aware that I am able to unsubscribe at any time.

_____ _____

Signature | Date

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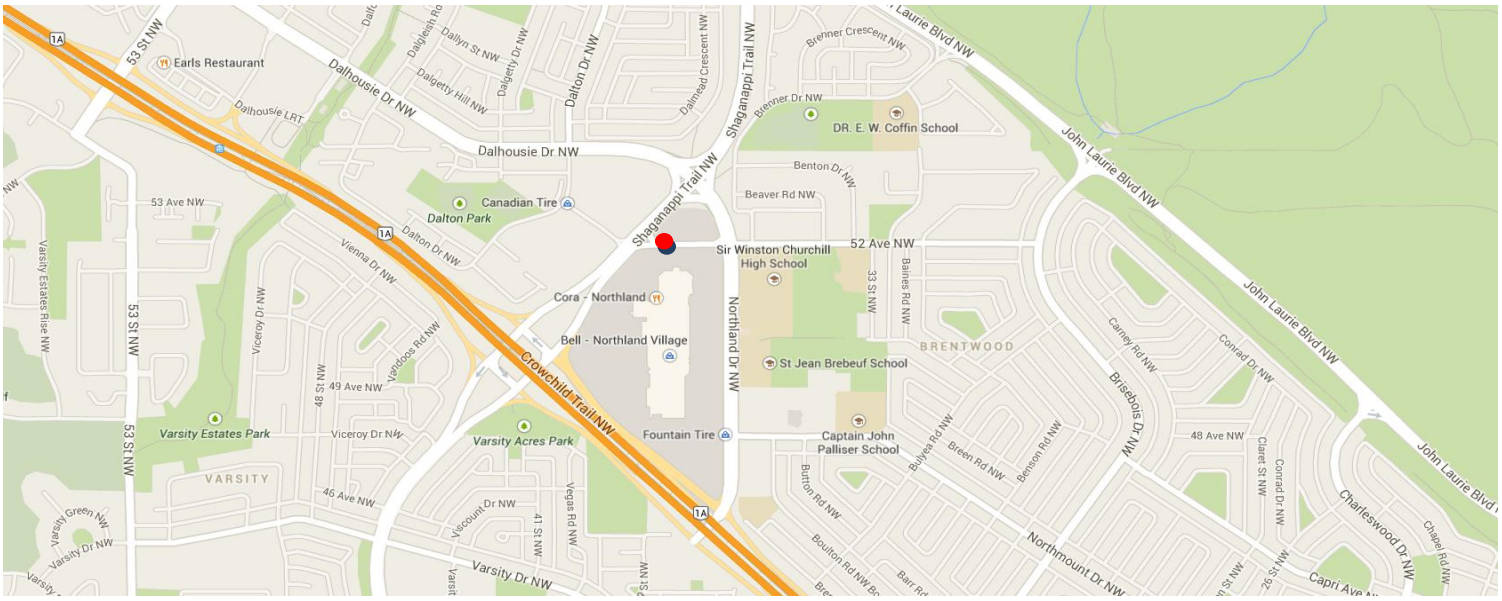

Our office is located in Northland Village Mall on the 2nd floor beside Winners. Please remember to bring your completed forms. We look forward to seeing you at your appointment!