



NEW PATIENT MEDICAL HISTORY

Welcome!

Our office has been designed for your total comfort and peace of mind. Each staff member will make every effort to see that your visit is a pleasant one. From the moment you arrive and relax in our comfortable reception area you will realize that this is a very special place where the highest quality standards are evident in every detail. It is this level of consideration and attention to detail that sets our office apart.

Most treatment only requires one or two visits; we make every effort to make sure your appointments are as comfortable as possible. Every detail of your visit has been carefully anticipated. Background music.... aromatherapy... televisions... large windows make for a sunny interior and set a relaxed tone. Blankets and refreshing hot towels are also available to make things cozy and of course, if you have any special requests to ensure your comfort please let us know. We definitely pamper our guests!

This letter is to help you understand what your "First Visit Experience" will be like. We take the time to review any past dental experiences, concerns or desires and to understand your wants and needs. Our office strives to be different and we believe you should be treated like an individual and not just "another patient". We will be taking a full series of radiographs if they need to be updated and records of your mouth (study models). Dr. Sayani will check for decay, perform an oral cancer screening, check the health of your gums and take photographs of your teeth. We will be happy to answer any questions you may have about your smile and overall dental health. Dr. Sayani may wish to see you back for a consultation to discuss any possible treatment before we begin.

Please take a moment to complete the health history questionnaire it can be faxed to us at 263-4041 or you can bring it in with you at your appointment. We look forward to meeting. If you have any questions before that time please feel free to call me at 403-263-4030, or visit our website at www.terradentalcare.com.

Yours truly,
TERRA DENTAL CARE

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DR. MEBS SAYANI PROFESSIONAL CORPORATION

210 - 530 8th Ave. S.W. • Watermark Tower, Calgary, Alberta, Canada T2P 3S8 • P: [403] 263-4030, F: [403] 263-4041
www.terradentalcare.com, info@terradentalcare.com



NEW PATIENT MEDICAL HISTORY continued

Patient Full Name: _____

Date of Birth: _____

Address: _____

Calgary, Alberta Postal Code: _____

Phone (Res): _____ Phone (Work): _____

Other (Cell): _____ Email: _____

Would you prefer to be reminded of your future appointment using this email address?

Yes No

If over 65; what is your ABHC#: _____

Who may we thank for referring you to our office _____

INSURANCE INFORMATION

Your Insurance Company Name: _____

Policy No: _____ I.D. No: _____

Spouse Insurance Company Name: _____

Policy No: _____ I.D. No: _____

Spouse's Name: _____

Date of Birth: _____

Date of last complete Medical Examination: _____

Weight: _____ Height: _____

Family Doctor: _____

List any medications that you are currently taking:

Medication	Quantity	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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NEW PATIENT MEDICAL HISTORY continued

Do you have any allergies to drugs or medication Yes No
Are you currently under medical treatment Yes No

Explain: _____

Have you had any of the following? (Please check)

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart surgery, disease, attack | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> High Blood pressure |
| <input type="checkbox"/> Artificial Heart valve | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Arthritis\Rheumatism |
| <input type="checkbox"/> Chest pain or shortness of breath | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Asthma, Hay fever, or |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anaemia | <input type="checkbox"/> Dizziness/Fainting/Stroke |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Artificial joints or hip | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Latex sensitivities | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Tumour or cancer |
| <input type="checkbox"/> Major Operations | <input type="checkbox"/> Vitamin/minerals | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Snoring | <input type="checkbox"/> Sleep with bed elevated |
| <input type="checkbox"/> Drink Alcohol | <input type="checkbox"/> Smoke or use tobacco | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Trouble breathing when asleep? | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Tonsil/adenoid problems or surgery | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Mitral valve prolapse (dysfunction) | <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Psychiatric/Psychological care | <input type="checkbox"/> A.I.D.S. | <input type="checkbox"/> H.I.V. Positive |
| <input type="checkbox"/> Weight change in the last year | <input type="checkbox"/> Sickle Cell disease | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Frequently don't eat breakfast | <input type="checkbox"/> Haemophilia | <input type="checkbox"/> Diet medically supervised |

Please list chronologically, names and types of doctors and their locations, whom you have seen in the past for any dental or medical related problems.

- a. _____
b. _____
c. _____

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NEW PATIENT MEDICAL HISTORY continued

DENTAL HISTORY

Date of last dental visit: _____ Last dental cleaning: _____

How often do you have your dental examination _____

Have you had:

Recent Dental x-rays: Full mouth series Panorex Bite wings

When _____

How often do you brush your teeth _____ Floss _____

What other dental aides do you use? (Example: Sonicare, Braun, toothpick, proxybrush, endtuft, etc.):

Do you have active dental problems now Yes, explain below No

	Y	N	
Gum disease	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	
Decay	<input type="checkbox"/>	<input type="checkbox"/>	
Broken teeth	<input type="checkbox"/>	<input type="checkbox"/>	Where _____
Have you experienced gum disease or tooth loss	<input type="checkbox"/>	<input type="checkbox"/>	
Have you noticed any mouth odours or bad taste	<input type="checkbox"/>	<input type="checkbox"/>	
Have you noticed any loose teeth or bite changes	<input type="checkbox"/>	<input type="checkbox"/>	
Does food get caught between your teeth	<input type="checkbox"/>	<input type="checkbox"/>	Where _____

Are any of your teeth sensitive to:

Hot or Cold Sweets
 Biting or Chewing Cold sores, blisters, or any other oral lesion

Have you ever had?

	Y	N		Y	N
Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	Oral surgery or teeth removed	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>	Endodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>
Your bite adjusted	<input type="checkbox"/>	<input type="checkbox"/>	Have you had general anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Have you had your jaw broken	<input type="checkbox"/>	<input type="checkbox"/>	Have you had your back teeth removed and not replaced	<input type="checkbox"/>	<input type="checkbox"/>

Have you had a cortisone injection into your joints Yes No

If yes, when _____ How many injections _____ By whom _____

Have you been given bite plate, splint, mouth guard, or orthotic Yes No

If yes, please describe reason: _____

Has your previous dentist ever had difficulty getting you frozen (numb) Yes No

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NEW PATIENT MEDICAL HISTORY continued

PERSONAL SMILE EVALUATION

When I see a picture of myself: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> I wish my teeth were whiter. | <input type="checkbox"/> I wish I had a wider or broader smile. |
| <input type="checkbox"/> My teeth have rough edges. | <input type="checkbox"/> My top teeth don't show enough. |
| <input type="checkbox"/> There is too much space between some of my teeth. | <input type="checkbox"/> I have discoloured areas between my teeth. |
| <input type="checkbox"/> I am not totally pleased with my smile. | <input type="checkbox"/> I sometimes hesitate to smile. |

- My teeth are: crowded crooked uneven overlapped
 My gums show: too much not enough when I smile
 I am interested in options available for enhancing my smile.

Occlusal Habits: Are you aware of any of the following habits?

- | | | | | |
|---|-----------------------------|-----------------------------|--|--|
| <input type="checkbox"/> Clench or grind your teeth | <input type="checkbox"/> AM | <input type="checkbox"/> PM | <input type="checkbox"/> Chew Gum | <input type="checkbox"/> Notice your front teeth hit first |
| <input type="checkbox"/> Bite Pencils | | | <input type="checkbox"/> Bite your cheek | <input type="checkbox"/> Smoke a pipe |
| <input type="checkbox"/> Bite your nails | | | <input type="checkbox"/> Notice your jaw is tired in the morning | |
- Other _____

Do you experience any of the following symptoms:

- Headaches: Migraines Tension Headaches Other _____

How often and where _____

- | | | | | | |
|-----------------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|
| | L | R | | L | R |
| Dizziness(Vertigo) | <input type="checkbox"/> | <input type="checkbox"/> | Ear congestion | <input type="checkbox"/> | <input type="checkbox"/> |
| Grating Sound in joints | <input type="checkbox"/> | <input type="checkbox"/> | Tinnitus (Ear Ringing) | <input type="checkbox"/> | <input type="checkbox"/> |
| Popping and/or clicking in joint | <input type="checkbox"/> | <input type="checkbox"/> | Pain in neck | <input type="checkbox"/> | <input type="checkbox"/> |
| | Y | N | | Y | N |
| Difficulty Chewing | <input type="checkbox"/> | <input type="checkbox"/> | Partial Inability to open mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| Face muscle Twitch | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing through nose | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Your Comfort:

- Do you think your teeth are affecting your general health Yes No
 Do you feel nervous about having dental treatment Yes No

If so, what is your biggest concern? _____

- Have you ever had an upsetting dental experience Yes No

If so, please describe _____

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NEW PATIENT MEDICAL HISTORY continued

Have you ever experienced:

Problems of prolonged bleeding either from a cut,
or a dental procedure such as cleaning?

Yes No

Have you ever been involved in an accident or
injury (sports injury, serious slip or fall, ski accident etc.)?

Yes No

When _____

What Happened _____

Did you start to have any dental problems after the accident. Explain: _____

For Women (optional)

Y N

Are you pregnant

Delivery Date _____

Have you reached menopause

Have you had a hysterectomy

Please write in any other information that we have not covered: _____

AUTHORIZATION: I, the undersigned, do hereby authorize and consent to the administration of all dental procedures deemed necessary or advisable for myself, or my child, by the attending dentist, including, but not limited to, the use of local anaesthetics, or other prescribed medication.

I shall assume responsibility for payment of all fees associated with the said procedures. I have reviewed the foregoing consent and authorization, and understand its contents.

Dated at the City of Calgary, this _____ day of _____ 20 _____

Signature _____

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PATIENT CONSENT FORM

Name: _____

Personal information means any information about an identifiable individual.

I understand that Dr. Sayani Professional Corporation operating as Terra Dental Care will be collecting personal information about me.

I consent to the collection, processing and retention of my personal information, as requested by Terra Dental Care, and understand that such personal information will be used for the purpose of providing me with the dental care as requested by me and compliance with applicable laws.

I further consent to the disclosure of such personal information to the extent necessary, to:

- (a) Terra Dental Care staff;
- (b) my insurance company;
- (c) any dental specialist that I am referred to;
- (d) to the extent required by law or government agencies.

I authorize Terra Dental Care and its representatives to request any necessary dental information including but not limited to, X-rays, from any previous dental office that I have attended.

I understand that:

- (a) my personal information will be retained in hard copy at the Terra Dental Care office where I submit this consent and in electronic form on secure servers located in Calgary, Alberta;
- (b) Terra Dental Care will take reasonable measures to safeguard the security and confidentiality of my personal information, including when dealing with third party recipients;
- (c) I have the right to access and review my personal information;
- (d) if I choose not to provide my consent to the collection, use and disclosure of my personal information as outlined above, Terra Dental Care's ability to provide me with care may be limited by law;
- (e) I may withdraw my consent provided hereunder at any time by providing written notice to Terra Dental Care; and
- (f) my personal information will be retained for as long as required by law and as necessary to fulfill the purpose described above, after which time it will be destroyed or deleted.

I fully understand the above consent statements and I am entering into them voluntarily, as certifies by my signature below.

Dated at the City of Calgary, this _____ day of _____ 20 _____ .

Signature _____

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Name: _____

We would like to take this opportunity to welcome you to our practice and explain our policies to you. If you have any questions or concerns, please feel free to ask any member of our staff.

OUR POLICIES

1. Payment: Our office accepts MasterCard, Visa, Interact, AMEX and Cash. We do not accept personal cheques. Our policy is to bill patients for all services rendered at the time of their appointment. As a courtesy to you, our staff will complete the dental portion of the claim form. To expedite processing, please ensure you provide our office with any changes in insurance coverage, address, and phone numbers.

Handling insurance in this way better enables you to see what benefits you are receiving and how well the insurance company is serving you.

2. Late or Missed Appointments: The time booked for your appointment has been reserved for you. We will contact you two (2) weeks prior for all pre booked appointments, and then two (2) days prior to your appointment. In consideration of our staff and other patients, we require at least two (2) business days notice on all cancellation or rescheduling of appointments.

If an appointment is missed, we do charge a rescheduling fee of \$100 per hour of the appointment that was missed, or any appointments cancelled with out 2 business days notice.

I understand Terra Dental Care requires at least 48 hours notice to cancel an appointment.

Missed appointment fees will be charged to credit card #: _____

exp: ____ / ____ / ____

Initials: _____

3. Insurance Coverage: Please be advised that dental insurance or benefits are by contact between you, your employer, and your insurance company. Under the Privacy Act, the majority of insurance companies will not provide our office with any details regarding your coverage.

Our objective as dental health care providers is to diagnose any treatment required according to each patient's particular needs. We do not know if your insurance will cover the treatment we diagnose as this is only outlined in your policy handbook.

If you require a "predetermination" we will provide a treatment plan for review by the third party payer. However, please remember that the financial obligation for treatment is between you and this office. The third party payer is responsible to you and not this office. If you require assistance in understanding your handbook, we would be happy to do so. Please be advised however, that a response from your insurance company may take four to six weeks to obtain.

We look forward to providing you with excellent dental care. If you have any questions or concerns, please feel free to ask any of our staff.

Yours truly,
Dr. Mebs Sayani Professional Corporation

THE UNDERSIGNED ACCEPTS THE ABOVE POLICIES AND AGREED TO ABIDE BY THEM:

Dated at the City of Calgary, this _____ day of _____ 20 _____ .

Signature _____

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