EST. 2018
DENTAL WELLNESS CENTRE OF ST. ALBERT

PATIENT CHART - PERSONAL INFORMATION

P: 780.569.0082 F: 780.569.0086 E: info@DentalWellnessStAlbert.ca

NAME

BIRTHDATE | AGE | GENDER

ADDRESS | POSTAL CODE

PHONE | CELL | OTHER

EMAIL | MARITAL STATUS

EMPLOYER | OCCUPATION

IF UNDER 18 YEARS OF AGE, PARENT/GUARDIAN

ALBERTA HEALTH CARD #

PERSON RESPONSIBLE FOR ACCOUNT

HOW DID YOU HEAR ABOUT US?

DENTAL INSURANCE

PRIMARY

NAME OF SUBSCRIBER | D.O.B.

INSURANCE PROVIDER

EMPLOYER

POLICY # | I.D.#

SECONDARY

NAME OF SUBSCRIBER | D.O.B.

INSURANCE PROVIDER

EMPLOYER

POLICY # | I.D.#

DENTAL HISTORY

LAST DENTAL OFFICE | PHONE

DATE OF LAST COMPLETE DENTAL EXAM | X-RAYS

PAST EXPERIENCE OF DENTAL TREATMENT

PRESENT DENTAL CONCERNS

HOW IMPORTANT IS IT TO KEEP YOUR TEETH?

IS THERE ANYTHING YOU WOULD CHANGE ABOUT YOUR SMILE?

BRUSHING YES / NO FREQUENCY

FLOSSING YES / NO FREQUENCY

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PATIENT CHART - MEDICAL HISTORY 1 of 2

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NAME OF PHYSICIAN _____ PHONE _____ DATE OF LAST EXAM _____

1.	Are you under the care of a physician now or within the last 2 years?	◯ YES	◯ NO
2.	Have you ever had a serious illness?	◯ YES	◯ NO
3.	Are you presently taking any medication?	◯ YES	◯ NO
4.	Do you smoke, use smokeless tobacco, use E-Cigarettes or cannabis?	◯ YES	◯ NO
5.	Are your activities limited? Do you become breathless easily?	◯ YES	◯ NO
6.	Do you have heart disease or a murmur?	◯ YES	◯ NO
7.	Do you suffer from high blood pressure?	◯ YES	◯ NO
8.	Have you ever had rheumatic fever?	◯ YES	◯ NO
9.	Do you have abnormal bleeding or bruising?	◯ YES	◯ NO
10.	Are your ankles often swollen?	◯ YES	◯ NO
11.	Have you gained or lost excessive weight recently?	◯ YES	◯ NO
12.	Do you faint easily?	◯ YES	◯ NO
13.	Do you have diabetes? ◯ Diet controlled? ◯ Insulin dependant? ◯		
14.	Have you ever taken cortisone or steroids or bisphosphonates?	◯ YES	◯ NO
15.	Have you ever been hospitalized? Why?	◯ YES	◯ NO
16.	Have you had previous surgery? If yes, please list:	◯ YES	◯ NO
17.	Do you have any allergies? If yes, please list:	◯ YES	◯ NO
18.	Are you allergic to any medications? If yes, please list:	◯ YES	◯ NO
19.	Have you ever experienced any unusual reactions to any of the following drugs? Aspirin ◯ Penicillin ◯ Iodine ◯ Sulfa Barbiturates (sleeping pill) ◯ Local Anesthesia ◯ Other ◯		
20.	Are you allergic to latex products? (ex. Swelling of lip after blowing balloon)	◯ YES	◯ NO
21.	Are you presently pregnant? If yes, how many months?	◯ YES	◯ NO
22.	Have you had radiation therapy to either hte head or jaw?	◯ YES	◯ NO
23.	To the best of your knowledge are you in good health? If no, explain:	◯ YES	◯ NO

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PATIENT CHART - MEDICAL HISTORY 2 of 2

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Are you afflicted with or have you been treated for any of the following:

Chest pain/heart attack	YES	NO	Dizziness	YES	NO
Thyroid Disease	YES	NO	AIDS/HIV	YES	NO
Epilepsy	YES	NO	Kidney Disease	YES	NO
Nervous Tension	YES	NO	Asthma	YES	NO
Cancer	YES	NO	Tuberculosis	YES	NO
Muscular Dystrophy	YES	NO	Liver Disease	YES	NO
Lung Problems	YES	NO	Cold Sores	YES	NO
Psychiatric Care	YES	NO	Sinusitis	YES	NO
Stroke	YES	NO			
Anemia	YES	NO			
Blood Disorders	YES	NO			
Hepatitis/Jaundice	YES	NO			
Stomach Problems	YES	NO			
Arthritis	YES	NO			

Any additional medical issues not listed above?

Please explain:

Please list all medications presently taking: