HILLHURST DENTAL CENTRE
DR. NENAD VRBANCIC

WELCOME TO OUR DENTAL OFFICE

Date: _____

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our administrative staff is available to assist you with the completion of this form. PLEASE PRINT.

Registration Information

Name: _____ Dr. ☐ Mr.☐ Mrs.☐ Miss☐

(last) (first)

Address: _____

(street) (apt. #) (city) (province) (postal code)

Home Phone: (_____) _____ Bus. Phone (____) _____ EXT. _____

Cell Phone: (_____) _____ Email: _____

Date of Birth: D: _____ M: _____ Y: _____ Age: _____ Sex: _____ Marital Status: _____

Are any other family member's patients at our office? Yes ☐ Name: _____

How did you hear about our office?

Friend/Relative: ☐ Name: _____ ☐Advertising ☐ Internet
☐Other_____

Insurance Information

Please complete ALL information if applicable:

Insurance Company Name: _____

Policy Holder: ☐Self ☐Spouse: _____

Group/Policy # _____

Member ID/Certificate # _____

Please complete if you have secondary insurance:

Insurance Company Name: _____

Policy Holder: ☐Self ☐Spouse: _____

Group/Policy # _____

Member ID/Certificate # _____

☐ I authorize Dr. Nenad Vrbancic to electronically submit my dental claims on my behalf.

713 - 14th Street N.W., Calgary, Alberta T2N 2A4
Tel: (403) 263-7779 Fax: (403) 263-7790 Email: info@hillhurstdental.ca
www.hillhurstdental.ca

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DR. NENAD VRBANCIC

MEDICAL HISTORY

Please check YES or NO to each question

	YES	NO
1)Are you being treated for any medical condition at present?	☐	☐

Medical Dr.'s name _____ Phone number _____

2) Have you been hospitalized in the past two years?	☐	☐
3) Has there been any recent change in your general health?	☐	☐

4) When was your last medical check up? _____

5) Have you recently taken or currently taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Please list: 1. _____ 2. _____ 3. _____

6) Have you ever reacted to any of the following? (please circle)

Aspirin Codeine Dalacin Keflex
Narcotics Penicillin Sulfa Valium
Local anesthetic(freezing) Other: _____

7) Do you have ANY other allergic conditions?	☐	☐
-metal allergy	☐	☐
-latex allergy	☐	☐
-other _____		
8) Have you ever been advised against any specific type of medication? Please list: _____	☐	☐
9) Have you been advised by a Medical Doctor or Dentist to take antibiotics prior to dental treatment?	☐	☐
10) Do you have a bleeding problem or disorder?	☐	☐
11) Do you use any type of tobacco products?	☐	☐
12) Have you tested HIV positive or come into contact with the AIDS virus?	☐	☐
13) WOMEN ONLY: Are you pregnant or suspect that you may be?	☐	☐

INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD

YES	NO	YES	NO	YES	NO
☐	☐ AIDS	☐	☐ GLANDULAR DISEASE	☐	☐ LUNG DISEASE
☐	☐ ANEMIA	☐	☐ FAINTING OR DIZZY SPELLS	☐	☐ MALIGNANT HYPERTHERMIA
☐	☐ ANGINA PECTORIS	☐	☐ HEPATITIS A, B, C (CIRCLE)	☐	☐ ORGAN TRANSPLANT
☐	☐ ARTHIRITIS	☐	☐ HEAD/NECK INJURIES	☐	☐ PSYCHIATRIC TREATMENT
☐	☐ ARTIFICIAL HEART VALVE	☐	☐ HEART DISEASE/ATTACK	☐	☐ RADIATION TREATMENT
☐	☐ ARTIFICIAL JOINTS	☐	☐ HEART MURMUR	☐	☐ RHEUMATIC/SCARLET FEVER
☐	☐ ASTHMA	☐	☐ HEART PACEMAKER	☐	☐ SICKLE CELL DISEASE
☐	☐ BLOOD DISORDERS	☐	☐ HEARTH RHYTHM DISORDER	☐	☐ SINUS TROUBLE
☐	☐ BRONCHITIS	☐	☐ HEART SURGERY	☐	☐ STOMACH/INTESTINAL PROBS
☐	☐ CANCER	☐	☐ HIV	☐	☐ STROKE
☐	☐ CIRCULATION PROBLEMS	☐	☐ HIGH BLOOD PRESSURE	☐	☐ THYROID DISEASE
☐	☐ CONGENITAL HEART LESIONS	☐	☐ LOW BLOOD PRESSURE	☐	☐ TUBERCULOSIS
☐	☐ CORTISONE/STEROIDS	☐	☐ HODGKINS DISEASE	☐	☐ ULCERS
☐	☐ DIABETES	☐	☐ HYPER (HYPO) GLYCEMIA	☐	☐ LIVER DISEASE
☐	☐ EMPHYSEMA	☐	☐ JAUNDICE	☐	☐ OTHER _____
☐	☐ EPIEPSY OR SEIZURES	☐	☐ KIDNEY DISEASE		

Do you wish to speak to the Doctor privately about any problem or medical condition? ☐ **YES** ☐ **NO**

_____ _____ _____

PRINTED NAME **SIGNATURE** **DATE**

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DENTAL HISTORY

Please check YES or NO to each question

Reason or today's visit? Examination ☐ Other ☐ _____
Date of your last dental visit: _____ Dental cleaning: _____
May we call your previous dentist for current x-rays? Yes ☐ No ☐
If YES, please provide the following:
Previous dentist: _____
Phone number: _____

	YES	NO
1) Is there a dental problem you would like treated immediately? Please describe: _____	☐	☐
2) Have you seen a dentist regularly?	☐	☐
3) Are you aware of any growths or sore spots in your mouth?	☐	☐
4) Do your gums bleed when brushing or eating?	☐	☐
5) Do you suffer from mouth pain or swelling?	☐	☐
6) Have you noticed any loose teeth or shifting of teeth?	☐	☐
7) Are any of your teeth sensitive to heat, cold, sweet or pressure? (Please CIRCLE)	☐	☐
8) Does food catch between any of your teeth?	☐	☐
9) Are you aware of clenching or grinding your teeth?	☐	☐
10) Do you suffer from frequent headaches?	☐	☐
11) Have you ever experienced the following jaw problems?	☐	☐
-popping or clicking in your jaw joints?	☐	☐
-pain in your jaw joints around your ears or side of your face?	☐	☐
-difficulty in opening or closing your jaw?	☐	☐
-painful or sore jaw muscles?	☐	☐
-pain or difficulty while chewing?	☐	☐
12) Are you missing any teeth?	☐	☐
-have you had the spaces replaced	☐	☐
-if NO, would you like them replaced?	☐	☐
13) Are you unhappy with the appearance of your teeth?	☐	☐
-what would you like changed? _____		
14) Are you interested in any of the following?		
☐ Teeth Whitening		
☐ Orthodontic treatment		
☐ Composite (white) fillings		
☐ Other: _____		
15) Are you feeling anxious about today's dental visit?	☐	☐

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Office Policies and Consent

Please review and initial each line.

Cancellations:

_____ At least two business days' notice is required for any appointment changes or cancellations. Office hours: Monday-Thursday 7:30am to 4:30pm.

_____ If sufficient notice is not given, a fee of $100 will be charged to your account.

Payment of Fees:

_____ We accept Cash, Debit, Visa, Mastercard and American Express.

_____ We offer direct billing, provided that we have a valid credit card left on file at all times.

_____ It is **your responsibility** to know the parameters of your insurance coverage – such as annual maximums, frequencies, renewal dates and any other limitations.

General Release:

_____ I certify that I have provided an accurate and complete personal and medical/dental history and I have not knowingly omitted any information.

_____ I authorize the communication of information related to the coverage of services described in this form to the named Doctor.

_____ I understand the above statements regarding the payment of fees and accept the responsibility for payment of Dental services provided for myself and/or my dependants, due and payable when services are rendered.

_____ _____

Patient/Guardian/Responsible Party Signature | Date

_____ _____

Patient/Guardian/Responsible Party Printed Name | Relationship to Patient (If Applicable)

_____ _____

Witness Signature | Date

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Consent for Credit Card Use

Name on Card: _____

Card Type: ☐ Visa
☐ Mastercard
☐ American Express

Card Number: _____

Expiry Date: _____

I authorize Dr. Nenad Vrbancic Professional Corp. to keep my credit card information on file and process my credit card if other payment arrangements are not made for outstanding invoices.

Signature: _____

Date: _____

Printed Name: _____

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