discovery dental

DISCOVERY DENTAL CENTRE

Dr. Fred Koslowsky
936 – 10 Discovery Ridge Hill SW
Calgary, AB T3H 5X2

Welcome! We are pleased to welcome you to our practice.
Please fill out this form as completely as you can.
The following information is essential for our staff to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to safely and efficiently protect your dental needs. Incorrect information can be dangerous to your health. If you have any questions, we would be glad to help you. We look forward to working with you in maintaining good dental health.

Name: _____ Date of Birth: ____/____/____ (M/D/Y)

Address: _____ Work Number: _____

_____ Home Number: _____

Postal Code _____ Other Number: _____

Occupation: _____ Email: _____

(Patients 18 years old and younger)
Parent or Guardian name and D.O.B (m/d/y) _____
How did you hear about our office: _____

INSURANCE INFORMATION

Discovery Dental does not accept payment directly from your insurance company, however we will assist you in receiving your reimbursement. Provided we have up to date coverage information, we are able to submit to many insurance companies electronically on your behalf.

Primary Carrier

Policy Holder Name:_____ D.O.B. m/d/y _____
Cert/ID # :_____ Division # :_____ Group/Plan # :_____
Name of Insurance Co: _____ Employer:_____

Secondary Carrier

Policy Holder Name:_____ D.O.B. m/d/y _____
Cert/ID # :_____ Division # :_____ Group/Plan # :_____
Name of Insurance Co: _____ Employer:_____

MEDICAL HISTORY

Physician's Name: _____ Phone Number: _____

Date of last visit to Dr: _____

1. Are you currently under the care of a physician? ☐ Yes ☐ No
2. Medications you are currently taking: _____
3. List drug/medication allergies: _____
4. Have you taken other drugs not listed above in the past 6 months (such as steroids, cocaine, any over the counter medications or herbal remedies or vitamins?) ☐ Yes ☐ No
   If yes, please list: _____
5. Have you had any serious illnesses or operations in the last five years? ☐ Yes ☐ No
   If yes, please describe: _____
6. Has there been any change in your general health in the past year? ☐ Yes ☐ No
   If yes, please list: _____
7. Have you ever had a reaction to local anesthetic? ☐ Yes ☐ No
   If yes, please describe: _____
8. WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No ☐ Maybe Nursing? ☐ Yes ☐ No
   Are you taking birth control pills? ☐ Yes ☐ No Hormone Medication? ☐ Yes ☐ No
9. Do you need to take antibiotic *premedication* before dental treatment? ☐ Yes ☐ No
   If yes, please list the condition: _____
10. Your current physical health is: ☐ Good ☐ Fair ☐ Poor
11. Please check off the box if you had or now have any of the following:

    ☐ AIDS or HIV ☐ Anaphylaxis ☐ Anemia ☐ Arthritis ☐ Artificial Heart Valves

    ☐ Artificial Joints ☐ Asthma ☐ Blood Disease ☐ Cancer ☐ Circulatory Problems

    ☐ Congenital Heart Problems ☐ Diabetes ☐ Excessive Bleeding ☐ Epilepsy

    ☐ Fainting ☐ Heart Problems ☐ Hepatitis, type ____ ☐ Herpes ☐ High Blood Pressure

    ☐ Jaundice ☐ Kidney Disease/Malfunction ☐ Liver Disease ☐ Latex Allergy

    ☐ Mitral Valve Prolapse ☐ Nervous Problems ☐ Pacemaker ☐ Psychiatric Care

    ☐ Radiation Treatment ☐ Respiratory Disease ☐ Stroke ☐ Surgical Implants, Kind _____

    ☐ Thyroid Disease ☐ Tobacco use, kind _____ ☐ Tonsillitis ☐ Tuberculosis

    ☐ Ulcers ☐ Venereal Disease
12. Do you have any other conditions that were not listed above? ☐ Yes ☐ No
    If yes, please describe: _____
13. Are you allergic to ASA, Codeine, Penicillin, Latex, Dental Anesthetics or Erythromycin?

    ☐ Yes ☐ No If yes, please describe: _____

DENTAL HISTORY

Do you have any present dental concerns? _____

Please check off the box if you had or now have any of the following:

☐ Abscess ☐ Bad Breath ☐ Bad Taste ☐ Bite Nails/Objects ☐ Bleeding Gums

☐ Blisters: ☐ Lip ☐ Mouth ☐ Clenching/Grinding of teeth ☐ Cold Sores

☐ Difficulty Chewing, where _____ ☐ Dry Mouth ☐ Gag Easily ☐ Loose Teeth

☐ Pain in Ears ☐ Pain in Jaw Joint ☐ Sensitive Gums ☐ Sensitive teeth ☐ Hot ☐ Cold ☐ Sweets

☐ Smoke – How many a day: _____ ☐ Chew – How much: _____

☐ Drink Alcohol ☐ Yes ☐ No If yes, how much a day: _____

Do you have any special concerns regarding your visit? ☐ Fear ☐ Time ☐ Money ☐ Tension

Please describe any previous problems you may have had with past dental treatment or special areas of concern you would like to have addressed by Dr. Koslowsky and his staff:

_____

_____

_____

_____

When was your last dental appointment? _____

How often do you see your dentist? ☐ 3 months ☐ 6 months ☐ 9 months ☐ Yearly

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Koslowsky and staff to help determine appropriate and healthful dental treatment. If there are any changes in my medical status, I will inform Dr. Koslowsky.
I authorize the use of this signature on all insurance submissions.
I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company.
Since at each visit treatment plans are presented and the work to be done is explained to me before treatment is begun I give Dr. Koslowsky my consent to perform any needed dental treatment, including the use of local anesthetic as needed.

_____

Patient Name (Printed) Patient Signature Date

I also give consent for the use of photographs for patient education purposes.

☐ **I agree** ☐ I disagree _____ Initial