GATEWAY
ORAL & MAXILLOFACIAL SURGERY

3838 Gateway Blvd. NW | Edmonton, Alberta | T6J 7A9
t: 780.760.1501 | f: 780.760.1502 | office@gatewayos.com
www.gatewayos.com

Patient Information Form

Alberta Health Care Number:

Name:
First Last

Age: **Date of Birth:** / / **Sex:** M F
MM DD YYYY

Home Address:

City: **Postal Code:**

Home Phone: **Mobile Phone:** **Email:**
Please Circle Best Method To Contact You

Emergency Contact: **Relationship to Patient:** **Contact Number:**

Referring Dentist:

Do you have dental insurance: ☐ No ☐ Yes

Primary Dental Insurance:

Insurance Company:

Name of Policy Holder:

Date of Birth:

Group/Policy Number:

Certificate/ID Number:

Secondary Dental Insurance:

Insurance Company:

Name of Policy Holder:

Date of Birth:

Group/Policy Number:

Certificate/ID Number:

If you are covered by Social Assistance please present your current card: ID #:

If you are covered by Indian Affairs please present your ID # and Band Name:

In this a worker's compensation claim: Y N Claim Number:

Acknowledgement

I understand that the information that I have given is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my demographic and medical status. Finally, I understand that this information will be held in the strictest of confidence.

I understand that that payment is due in full at the time of treatment unless prior arrangements have been approved and signed. With regards to accepted insurance payments, I understand that I am responsible for the payment of services rendered and also responsible for paying any co-paymnets and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office otherwise payable to me. I also authorize the release of any information, including examination, diagnosis and treatment records to my insurance company.

Patient's Signature **Date:** / /
MM DD YYYY

Personal Health History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: Contact Number:

Have you been treated by a physician in the past year? ☐ Yes ☐ No

If yes, please explain:

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

If yes, cigarettes per day: Number of years:

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please describe:

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Have you been hospitalized in the past 5 years? ☐ Yes ☐ No

If yes, please explain:

Have you ever had a general anesthetic? ☐ Yes ☐ No

Have you had surgery in the past 5 years? ☐ Yes ☐ No

If yes, please explain:

Please list all medication (including frequency and dose) that you are presently taking:

1. 2. 3.

4. 5. 6.

Are you taking any blood thinners (Coumadin/Warfarin, Plavix, Aspirin)? ☐ Yes ☐ No

Please list:

Do you take or have you ever taken bisphosphoneate medications (Fosamax, Actonel) for osteoporosis or cancer treatment? ☐ Yes ☐ No

Have you ever had radiation or chemotherapy? ☐ Yes ☐ No

Do you have any artificial joints or prosthetic implants? ☐ Yes ☐ No

Have you had a heart valve replacement (artificial heart valve)? ☐ Yes ☐ No

For women only:

Are you taking the birth control pill? ☐ Yes ☐ No

Are you currently pregnant or is it possible that you could be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Have you had or currently have any of the following medical issues:

High Blood Pressure	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Intestinal Problems	☐ Yes ☐ No
Heart Attack or Disease	☐ Yes ☐ No	Bronchitis	☐ Yes ☐ No	Gastrointestinal Ulcers	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Hepatitis A,B,C	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	HIV / AIDS	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Sickle Cell Disease / Trait	☐ Yes ☐ No	Cortisone, Prednisone or Steroid Therapy	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Easily Bruise	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Abnormal/Prolonged Bleeding	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No

For Office Use Only:

I verbally reviewed the medical / dental information with the patient named herein.

Initials: Date: / /
MM DD YYYY

Changes in health status since last visit:

Initials: Date: / /
MM DD YYYY