

blunston

DENTAL GROUP

#1 620 1st Ave NW, Airdrie, AB T4B 2R3
p. 403.912.9378 f. 403.912.9377
info@blunstondentalgroup.com
BlunstonDentalGroup.com

Be your best.

Personal Information

Family Name _____ First Name _____
Date of Birth m/d/y _____ Social Insurance/Driver's License # _____
Address _____
City _____ Province _____ Postal Code _____
Home Phone# _____ Work Phone# _____ Other Phone# _____
Email Address _____

Insurance Information

Name of Insured _____
Date of Birth m/d/y _____
Name of Employer _____ Work Phone _____
Address of Employer _____
City _____ Prov. _____ Postal Code _____
Insurance Company _____ Group# _____ Policy/ID# _____

DO YOU HAVE ANY ADDITIONAL INSURANCE?

Yes No

IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____
Date of Birth m/d/y _____
Name of Employer _____ Work Phone _____
Address of Employer _____
City _____ Prov. _____ Postal Code _____
Insurance Company _____ Group# _____ Policy/ID# _____

CONFIDENTIAL

Health History

Do you have or have you ever had any medical condition affecting the following body systems?

- Heart, Lungs or Circulation
- Immune System
- Nervous System/Brain
- Muscles and/or Joints
- Digestive System
- Skin Disorders
- Reproductive System
- Are you currently pregnant?
- Other _____

Are you allergic to or have you ever had any reactions to the following?

	Yes	No		Yes	No
Local Anesthetics (e.g. novocaine)	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin and/or other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Any metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>			
Other (please list) _____					

Family Physician _____ Date of Last Exam _____

Are you currently under the care of a physician? If yes, please explain.

Are you currently taking any medications and/or over-the-counter supplements/herbs? If yes, please list.

Have you ever had complications following dental treatment? If yes, please explain.

Have you ever been admitted to the hospital or needed emergency care during the past 2 years? If yes, please explain.

Consent for Services

By signing below, patients agree to pay all fees applicable for services provided by Blunston Dental Group. Patients who carry dental insurance understand that fees are charged directly to the patient, who is personally responsible for payment. Blunston Dental Group does not accept direct billing from insurance companies.

A service charge of 2% per month will be charged on all unpaid balances exceeding 60 days, unless a financial arrangement has previously been made. Any other collection or legal charges that may be incurred in this regard are also the responsibility of the patient.

Signature of patient/guardian _____

Date _____