LASER ASSISTED DENTISTRY

PATIENT INFORMATION

First Name______________________Last Name _____________________________ Date of Birth ___________
Address____
Home Phone #______________________ Business ____________________ Cell_______________________
Email Address_______________________________________ Occupation________________________________

Dental Ins. Co.#1___________________ Name of Card Holder & Employer________________________________
Group/ Policy #____________________ Employee # or ID#____
Dental Ins Co #2____________________ Name of card holder & Employer________________________________
Group/Policy #_____________________ Employee# or ID #____
Physicians Name ___________________ Phone #_______________ Alberta Health Care#___________________
Emergency Contact____________________Phone#______________Relationship_________________________
Other family members in our practice___________________ Referred by________________________________

Date ___ /___ /_____ (mm/dd/yy)

Medical History

1. Have you had any serious medical conditions or surgeries requiring hospitalization?_____________ Yes No
   If yes, please specify____
2. Have you had any complications or adverse reactions to general or local anaesthetic?____________ Yes No
3. Do you have any allergies, such as food, medications, environment, local anaesthetics, latex?______ Yes No
4. Are you currently taking any medication or herbs regularly? ________________________________ Yes No
   Please list____
5. Do you bruise or bleed easily?____ Yes No
6. Do you smoke?____ Yes No
7. Have you ever had any of the following? (Please Circle any that apply).
   - Heart Attack - Bleeding Problems - Hepatitis A /B /C - Stroke
   - Rheumatic Fever - Organ Transplant - High Blood Pressure - Epilepsy
   - Glaucoma - Asthma or Bronchitis - Heart Murmur - Jaundice
   - Artificial Joints/ Hip- Pacemaker - Tuberculosis - Diabetes
   - Mental or Nervous disorder -Cold Sores - HIV / AIDS - Cancer
8. **WOMEN ONLY**
   Are you pregnant? _________ Yes No ______ Do you take Oral Contraceptives? ____________ Yes No
9. Do you Snore? ____________ Yes No ______ Do you have a C-Pap? _________________________ Yes No
10. Do you use Recreational Drugs (marijuana/Cocaine)? ____ Yes No

NOTES: ____
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Medical History Update:

Date	Same / Change	Patient Signature	Dr. Initials	Date	Same / Change	Patient Signature	Dr. Initials
________	--	____________________	________	________	--	____________________	______
________	--	____________________	________	________	--	____________________	______
________	--	____________________	________	________	--	____________________	______
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LASER ASSISTED DENTISTRY

Dental History **Date:______________** **Medical Alert__________________________________**

1. When was your last visit to a dental office?____
2. What dental problem concerns you, at the present time? ____
3. Do you have a problem with local anaesthetic (freezing)? _________________________________ Yes No
4. Are you nervous or worried about receiving dental treatment?_____________________________ Yes No
5. Do your gums bleed when you brush or floss? ____ Yes No
6. Are your teeth sensitive to hot, cold, sweet or touch? _____________________________________ Yes No
7. Is bad breath or a bad taste in your mouth a concern? ____________________________________ Yes No
8. Do you have sores or swelling in or around your mouth?___________________________________ Yes No
9. Do you clench or grind your teeth? ____ Yes No
10. Do have any Jaw (joint) problems (clicking/ popping / difficulty opening or closing your mouth)? _____ Yes No
11. Do you suffer from headaches? ____ Yes No
12. Do you wear a dental appliance? ____ Yes No
13. Do you gag easily? ____ Yes No
14. Are you interested or have you ever thought of: (please circle all that apply)
    Whitening Crowns Veneers Closing the spaces between teeth Replacing missing teeth
15. Is there anything regarding your medical or dental history that we have not discussed, which would be Important for us to know prior to treatment?

____

____

16. Would you be interested in esthetics and cosmetic procedures?
    a. Non surgical skin rejuvenation with light and lasers?________________________________ Yes No
    b. Injectables (Botox/ Fillers)____ Yes No

You are responsible for all financial obligations for your dental care services.

I authorize routine diagnostic and major procedures, and if I accept the proposed program, I agree anesthetics and pre-medications as considered necessary of advisable by the dentist responsible for this service.

X________________________________ ________________________________

SIGNATURE DATE

LASER CONSENT-RISKS AND DISCOMFORTS

During laser treatment, you may find there is a offensive odor and a popping sound. You may also experience minor discomfort. Possible damage to the unprotected eye can occur when exposed to direct or reflective laser light. Therefore, you will be required to wear appropriate protective glasses during all laser treatments. If the area of therapy does not respond, a referral to a Specialist may be recommended.

I have read the foregoing and have asked and received responses to any questions which I may have regarding the risks associated with the use of lasers.

X________________________________ ________________________________

SIGNATURE DATE