Welcome to Cumberland Dental! Below are our office policies.

- We require a minimum of **24 hours notice** to cancel OR change any appointment. A **$58.00 fee will be charged** if an appointment is missed or cancelled without sufficient notice.
- We offer a reminder notice the day before your appointment. **Please note that this is a courtesy notice.** If you do not receive our notice, you are ultimately responsible for missing the appointment that you scheduled.
- Our office provides electronic/manual billing to your insurance company on your behalf. You are responsible for providing the necessary information for us to direct bill your insurance company as well as informing us of any changes in this information.
- Due to the privacy act, you are responsible to monitor your plan's coverage and maximums. If your insurance does not cover your treatment, you are responsible to cover the cost at the time each service is rendered unless other arrangements have been made.
- All fees charged are those set out by the College of Dental Surgeons of Saskatchewan.

I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and will assume responsibility for fees associated with these procedures. I have read and agree with the policies of Cumberland Dental.

Signature ________________________________ **Date** ________________________________

Patient Registration

Name ____ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐
Last First Middle Initial

Preferred Name __________________________ Preferred Pronouns He/Him ☐ She/Her ☐ They/Them ☐

Date of Birth __________________________ Age _______ Patient Sex M ☐ F ☐
DD / MM / YYYY

Saskatchewan Health # ________________________ Treaty Status # ________________________

Address ____
Apt. Street City Province Postal Code

Home Phone (______)_________________ Cell Phone (______)_________________

Work Phone (______)_________________ Email Address ________________________________

Occupation ____________________________ Employer ____________________________________

In case of emergency, notify ________________________ ________________________ (______)_________________
Name Relationship Phone

Method of Payment for Dental Treatment

☐ Cash
☐ Cheque
☐ Visa
☐ Mastercard

☐ Social Services
☐ Indian Affairs
Band name _______________

☐ Dental Insurance
Company ____________________
Group/Policy #__________________
Certificate/ID # _________________
Division # ____________________

If not you, person responsible for account:

Name ____ Phone (____)___________ Date of Birth _________________
Last First Middle Initial DD / MM / YYYY

Address ____
Apt. Street City Province Postal Code

Other family members who come to our office ____

How do you prefer to be contacted for your appointment? Phone ☐ Text ☐ Email ☐

How did you hear about us? Referred by a friend ______________________ **Online** ☐ **Other** __________________
Friends Name **Please Specify**

Medical History

1. Are you presently in good health? ☐ **Yes** ☐ **No**
   Date of last medical examination ______________________

2. Have you ever had a serious illness requiring hospitalization or extensive care? ☐ **Yes** ☐ **No**
   Explain____

3. Is a physician treating you now? ☐ **Yes** ☐ **No**

4. Are you taking any kind of medication? Please list ____ ☐ **Yes** ☐ **No**
   ____

5. Have you ever experienced an unusual reaction to:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal, Plastics, Latex
☐ Tylenol ☐ Sulpha ☐ Ibuprofen ☐ Other __________________

6. Do you have or have you ever had:

☐ AIDS/ARC/HIV+ ☐ Hepatitis A/B ☐ Sinus Trouble ☐ Hay Fever ☐ Organ Transplants
☐ Arthritis ☐ Herpes/Cold Sores ☐ Stroke ☐ Mental/Nervous disorder ☐ Tuberculosis
☐ Asthma ☐ Heart Problems ☐ STD ☐ Severe Headaches ☐ Thyroid Disease
☐ Cancer ☐ Heart Murmur ☐ Multiple Sclerosis
☐ Diabetes ☐ Stomach Ulcers ☐ Rheumatic Fever ☐ Other_________________
☐ Epilepsy/Seizures ☐ Joint Replacement ☐ Blood Disorders _________________________

7. Do you have allergies? Specify____ ☐ Yes ☐ No
8. Do you bruise or bleed easily? ☐ Yes ☐ No
9. Do you ever have chest pains or shortness of breath? ☐ Yes ☐ No
10. Have you ever had radiation or chemotherapy? ☐ Yes ☐ No
11. Have you ever fainted? ☐ Yes ☐ No
12. Do you smoke? ☐ Yes ☐ No

13. Women only: Are you pregnant? If so, which month _____________
    Are you nursing? ☐ Yes ☐ No
    Are you taking birth control pills? ☐ Yes ☐ No

Dental Health

1. Reason for present dental visit ____
   ____

2. Do you have or have you ever had:

☐ Fillings ☐ Gum Disease ☐ Crowns ☐ TMJ Problems
☐ Root Canals ☐ Dentures ☐ Bridges ☐ Oral Surgery
☐ Toothaches ☐ Orthodontics ☐ Trauma to the head/neck

3. Are any of your teeth sensitive to ☐ Heat ☐ Cold ☐ Sweets

4. Do you clench or grind your teeth? ☐ Yes ☐ No

5. Do you have pain or hear any noises in your jaw joints? ☐ Yes ☐ No

6. Has your jaw ever locked open or closed? ☐ Yes ☐ No

7. Have you had any troubles with local anesthetic (freezing)? ☐ Yes ☐ No

8. How often do you brush? ________ x Day Floss? ________ x Week

9. How frequently do you see the dentist? ☐ 6 months ☐ Yearly Last Visit ________________________

10. Are you concerned with the appearance of your teeth? If so, specify ____

11. Is there any other information that should be known about your health or previous dental visits? ____
    ____