Dr. Albert Lui
& Associates

Our office complies with the highest sterilization standards recommended by Alberta Health Services. All instrument cycles are tested and recorded.

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Date of Birth(day/month/year): ___/___/_____Email address_____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

_____
City Province Postal Code

Emergency Information

Whom shall we contact in case of an emergency? _____

Relationship _____ Phone # _____

Health Information

Name of Dentist: _____ Date of last dental exam:_____

Name of Medical Doctor: _____ Date of last check up: _____

Have you ever had any of the following? Please check those that apply:

- Anemia
- Arthritis
- Asthma
- Artificial Joint(s)
- Blood Disorder
- Cancer/Tumor
  - Chemo
  - Radiation
- Crohn's Disease
- Colitis
- Diabetes
  - Type I
  - Type II
- Epilepsy
- Fainting or dizzy spells
- Glaucoma
- Graves Disease
- Hay Fever

- Head Injury
- Head Aches
- Heart Disease
- Heart Murmur
- Herpes (Cold Sores)
- Hepatitis A B or C
- HIV/AIDS
- High Blood Pressure
- IBD
- Kidney Disease
  - Dialysis
- Lyme Disease
- Liver Disease
  - Jaundice
- Lupus
- Mental Illness
- Multiple Sclerosis
- Organ Transplant
- Pacemaker
- Respiratory Problems
- Rheumatic fever
- Rheumatism
- Stroke
- Thyroid Disease
- Tuberculosis
- Ulcers
- Sjogren's Syndrome
- STI
- Vertigo
- Other: _____

List all allergies:

_____

_____

_____

_____

Have you or any member of your family ever been diagnosed with CJD (sporadic, familial or iatrogenic), Gerstmann-Straussler-Sheinker syndrome (GSS), fatal familial insomnia (FFI) or any other prion disease? ☐ Yes ☐ No

Have you ever received growth hormone or gonadotrophin infertility treatments? ☐ Yes ☐ No

Have you ever had surgery on your brain or spinal cord? ☐ Yes ☐ No

Have you been told that you need to take pre-medication (antibiotic coverage) prior to a dental visit? ☐ Yes ☐ No
If yes, please explain:_____

Please list all prescription, non-prescription medications and/or supplements you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever been advised against taking any specific type of medication? ☐ Yes ☐ No
If yes, please list:_____

Do you use or are addicted to any illicit drugs? ☐ Yes ☐ No
If yes, please list: _____

Do you smoke or use any form of tobacco or cannabis? ☐ Yes ☐ No
If yes, please list:_____

Do you currently use a CPAP? ☐ Yes ☐ No

Have you been hospitalized in the last 2 years? ☐ Yes ☐ No
If yes, please explain:_____

Have you had recent exposure to communicable infectious disease (measles, chickenpox, TB, travel to endemic area)?
☐ Yes ☐ No
If yes, please explain:_____

In the last 24 hours have you had a new cough, shortness of breath, fever, chills, diarrhea or other influenza type symptom? ☐ Yes ☐ No
If yes, please explain:_____

Have you ever had any injury or surgery to your face or jaw? ☐ Yes ☐ No
If yes, please explain:_____

Do you have any bleeding problems? ☐ Yes ☐ No
If yes, please explain:_____

Do you bruise easily? ☐ Yes ☐ No

For Women Only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment. Any misrepresentations made to the dentist by myself with respect to my medical history will release Dr. Lui, A. Lui Prof Corp., Dr. Jazmin Lui, Jazmin Lui Professional Corporation, Dr. Andres Marquez-Guzman, A. Marquez-Guzman Professional Corporation and his/her employees, servants, partners, agents and/or corporation of any liability.

_____ Date:_____
Signature of patient, parent or guardian

Insurance and Referral Information

Please provide our office with your insurance information.

Whom may we thank for referring you to our practice? ☐Another patient ☐ Friend, relative

☐ Dental Office ☐ Denturist ☐ Internet ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Reason for referral: _____

Consent for Services

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. Should there be any change in my health status in the future, I will advise Dr. Lui, A. Lui Prof Corp., Dr. Jazmin Lui, Jazmin Lui Professional Corporation, Dr. Andres Marquez-Guzman and/or A. Marquez-Guzman Professional Corporation. I authorize Dr. Lui, A. Lui Prof Corp., Dr. Jazmin Lui, Jazmin Lui Professional Corporation, Dr. Andres Marquez-Guzman and/or A. Marquez-Guzman Professional Corporation to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor, a referring Dentist, Denturist or another healthcare provider may be necessary and I consent to the release of this information.

_____: Initial

I assume responsibility for fees associated with these procedures and am aware that payment is due in full at the time of services rendered. I am aware that Dr. Lui, A. Lui Prof Corp., Dr. Jazmin Lui, Jazmin Lui Professional Corporation, Dr. Andres Marquez-Guzman and/or A. Marquez-Guzman Professional Corporation will not be responsible for any expenses not covered by my dental insurance plan. I understand that if I chose to discontinue a continuing treatment plan and complete the treatment with another provider, Dr. Lui, A. Lui Prof Corp., Dr. Jazmin Lui, Jazmin Lui Professional

Corporation, Dr. Andres Marquez-Guzman, A. Marquez-Guzman Professional Corporation and his/her employees, servants, partners, agents and / or corporation of any liability are released from any liabilities that may arise.

I understand that a fee will incur when 48 hours notice of a cancelled appointment is not given.

I authorize Dr. Lui, A. Lui Prof Corp., Dr. Jazmin Lui, Jazmin Lui Professional Corporation, Dr. Andres Marquez-Guzman and/or A. Marquez-Guzman Professional Corporation to send my insurance claims through electronic submission and to secondary company if applicable.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient:
Signature of guarantor of payment/responsible party