Dr. Albert Lui
& Associates

CANADA PLACE DENTAL
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

Gender: _____ ☐ 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: _____
Pharmacy:_____

Do you have 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 (circle):
  - Type 1/Type 2
- Epilepsy
- Fainting or dizzy spells
- Fibromyalgia
- Glaucoma
- Graves Disease
- Hay Fever
- Head Injury
- Headaches (Chronic/Migraines)
- Heart Disease
- Heart Attack
- Heart Murmur
- Herpes (Cold Sores)
- Hepatitis A B or C
- HIV/AIDS
- High Blood Pressure
- IBD

- Kidney Disease (Dialysis?)
- Lyme Disease
- Liver Disease
- Lupus
- Mental Health Condition
  - Anxiety
  - Bipolar
  - Depression
  - Schizophrenia
  - Other: _____
- Multiple Sclerosis
- Organ Transplant
- Osteoporosis
- Pacemaker
- Respiratory Problems
- Rheumatic fever
- Rheumatism
- Stroke/aneurysm
- Thyroid Disease
- Tuberculosis
- Ulcers
- Sjogren's Syndrome
- STI
- Sinus issues
- Sleep apnea

List all allergies:

_____

_____

Reason for today's visit to our office:

- Presently in pain
- Teeth cleaning
- Missing teeth/implants
- Sensitivity to hot/cold
- Cavities/broken teeth
- Straightening teeth/Invisalign
- Whitening
- Grinding/clenching
- Smile makeover
- Other: _____

Dental History

- Bleeding gums
- Bone loss
- Tooth loss
- Prone to cavities
- Orthodontic treatment (braces)
- Nightguard (grinding/clenching)
- Dental anxiety
- Jaw joint/TMJ pain
- Dentures
- Implants

Have you had a negative experience with dental treatment? _____

For Women Only: Are you breast-feeding or pregnant? ☐ Yes ☐ No Expected delivery date: _____

Please list any form of birth control medication being taken: _____

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:_____

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

Have you had an adverse reaction to any drug? ☐ Yes ☐ No If yes, please list: _____

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

Have you ever taken bone medications (oral or injection) such as Fosamex, Prolia, etc? ☐ Yes ☐ No

Do you have a history of use of 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 along with how many days per week used (smoking: packs per day):
_____

Do you currently use a CPAP? ☐ Yes ☐ No

Have you had recent exposure to communicable infectious diseases (COVID-19, measles, chickenpox, TB)?
☐ 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

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 without fail.

_____ 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 the dental office of Dr. Albert Lui and Associates. I authorize Dr. Albert Lui & Associates 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.

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. Albert Lui & Associates 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. Albert Lui & Associates 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. Albert Lui & Associates 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