SALMONARM Dental

EMERGENCY FORM

Dr. Russell Kearl
Dr. Andrew Irwin

PATIENT INFORMATION

Legal Name:_____ ❑Male ❑Female
Last First Middle

Preferred Name:_____Date of Birth (D/M/Y):_____

Phone:_____Cell: _____ Work: _____ Ext:_____

Address: _____City_____Prov_____**Postal Code**_____

E-mail:_____ Occupation:_____

Emerg Contact:_____Relation:_____Phone:_____

How did you hear about us? ❑Google ❑Sign ❑Facebook ❑Website ❑Yellow Pages ❑Radio ❑Newspaper ❑Kong

❑Friend (Who do we thank?)_____❑Other_____

Office Policies

Insurance companies will only pay a portion of your treatment. It is your responsibility to pay the balance not covered.

There is an after hours fee of **$150.00** that will be due upon treatment. This fee is not covered by dental insurance plans.

For after hours treatment you are required to pay for your treatment up front and submit to your own insurance provider.

Cancelation of appointments with less than 48hrs notice may be subject to a $50 Cancelation fee.

An **Emergency** or **Specific** Exam focuses on an urgent issue. It is still y**our responsibility** to come for a **regular check up and cleaning**.

All medical treatments carry with them a certain amount of risk. These risks are greatly minimized when you make your Dentist aware of existing concerns. Not informing your dentist, of medications, allergies, existing or past medical conditions, or recreational drug use, may lead to severe conditions or death. Please do your best to make sure that your medical information is always up to date.

One risk of dental treatment although rare is paresthesia. This is where a nerve that has been frozen or otherwise traumatized may temporarily or permanently loose feeling in the tongue and/or lip.

HEALTH INFORMATION

Name or Office/City of your regular dentist if other than here:_____

Name of General Physician:_____

Reason for todays visit:_____

List any allergies you have:_____

List any medications you are taking (Blood Thinners, etc.):_____

List any recreational drugs taken recently: (**Some interactions may be LETHAL.**):_____

Have you ever had a Heart Attack, Stroke, or TIA (and when):_____

❑Other Medical issues that we should be aware of, or clarification on any of the above:_____

_____

_____

_____

_____

This information is accurate to the best of my knowledge and I will inform the dentist if there are any changes.

_____ _____
Signature of Patient/Guardian Date