WELCOME TO OUR DENTAL OFFICE

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

LAST NAME_____ FIRST NAME_____PREFER TO BE CALLED _____

Birthdate D-_____ /M-_____ /Y-_____ Marital Status: ❒-S ❒-M ❒-W ❒-Sep. ❒-Others Sex: ❒-F ❒-M

Home Address _____ Apt#_____ City_____

Postal Code _____-_____ Home Phone (____) _____-_____ Work Phone (_____) _____-_____ Ext.#_____

Cellular Phone/Pager (____) _____-_____ Email _____ Occupation _____

INSURANCE INFORMATION

Person Responsible for Account ❒-self, ❒-spouse, ❒-other name _____

Relationship to you _____Birthdate D-_____ /M-_____ /Y_____ Occupation_____

Employer _____ Work Phone # (_____) _____-_____ Ext.# _____

Primary Insurance _____ Group/Plan # _____ Cert#/SIN/ID#_____

Secondary Insurance ❒-yes ❒-no Insurance Company _____
(in case you or your spouse has secondary coverage)
Employer _____ Group/Plan # _____ Cert#/SIN/ID#_____

Emergency Contact Name_____ Phone # (____) _____-_____ Relationship _____
Reason for Today's First Visit:
❒-complete examination ❒-emergency ❒-consultation; (ortho, wisdom teeth, implant, endo)
❒-other concerns _____

How did you hear about our practice? _____

MEDICAL HISTORY

Name of Family Physician _____ Phone # (____)_____- _____

Address _____

Date of the last visit _____ Reason for last visit_____

- Are you presently under the care of a physician? _____ ❒-yes ❒-no
  If so, what is the condition being treated?_____
- Do you use any prescription or non-prescription medicine regularly? Specify: _____

_____

- Do you have or have you ever had any of the following? _____ ❒-yes ❒-no

❒-Heart Attack
❒-Chest Pain
❒-Stroke
❒-Heart Murmur/Mitral Valve Prolapse
❒-High Blood Pressure
❒-Low Blood Pressure
❒-Rheumatic Fever
❒-Kidney Problems
❒-Liver Problems
❒-Jaundice
❒-Hepatitis: ❒-A, ❒-B, ❒-C
❒-Diabetes:
❒-Type I Insulin Dependant
❒-Type II Non-Insulin Dependant
❒-Epilepsy/Seizure
❒-Thyroid
❒-Tuberculosis (TB)
❒-Blood Disorder
❒-Bleeding Tendencies
❒-Anemia
❒-AIDS
❒-HIV (positive)
❒-Sexually Transmitted Diseases
❒-Asthma
❒-Lung/Breathing Problems
❒-Stomach/Intestinal Problems
❒-Fainting Spells
❒-Mental/Nervous Disorders
❒-Drug Addiction
❒-Radiation or ❒-Chemotherapy
❒-Cancer
❒-Serious Operations
❒-Serious Illness
❒-Allergy
❒-_____
❒-Prosthetic Joints
❒-Arthritis
❒-Eating Disorders
❒-_____
Notes _____
_____
_____

- Have you had an allergic reaction or unusual reaction to any of the following? ..... ❒-yes ❒-no

  ❒-Penicillin ❒-Codeine ❒-_____
  ❒-Erythromycin ❒-Dental/Local Anaesthetic (freezing)

- Have you ever been hospitalized for any serious operations or illness? ..... ❒-yes ❒-no
- Do you smoke or chew tobacco? ..... ❒-yes ❒-no
  If yes, how many packs/day? _____, for how many years? _____.
- Female Only. Are you pregnant? ..... ❒-yes ❒-no
  If yes, what is the expected delivery date? _____

DENTAL HISTORY

- Previous Dentist Name_____ Phone # (_____) _____- _____

  Address .....
- How frequently do you see your dentist? .....❒-3 months ❒-6 months ❒-9 months ❒-yearly ❒-Other
- Last Dental Visit _____ Last Cleaning _____ Last Full Set of X-rays .....
- Did you use the same insurance coverage during your last dental visit? ..... ❒-yes ❒-no
- Do you have any abnormal growths, swelling, or bleeding in your mouth? ..... ❒-yes ❒-no
- Are you sensitive to objects placed in your mouth or are you easily prone to vomit..... ❒-yes ❒-no
- Have you ever been advised to take antibiotics before a dental appointment? ..... ❒-yes ❒-no
- Cleaning aids presently used: ❒-floss ❒-stimudents ❒-toothpicks ❒-electric toothbrush ❒- .....
- Do you have any emotional concerns regarding your dental visit? ..... ❒-yes ❒-no
  ❒-fear ❒-pain ❒-time ❒-money ❒-embarrassment ❒-_____
- Are you happy the colour of your teeth? Have you ever considered the teeth whitening? ……..❒-yes ❒-no

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OFFICE POLICY

- √ All fees charged are those set out by the current Ontario Dental Association.
- √ Payment is required each time service is rendered.
- √ Your appointment time will be reserved especially for you. If you are unable to deep the appointment we require 48 hours notice, otherwise it may be necessary to charge for the time lost ($50 per half hour)
- √ A change in your health status should be reported to the office at the earliest possible time.

PATIENT CONSENT (PARENT OR GUARDIAN SHOULD SIGN FOR CHILDREN UNDER 18 YEARS OF AGE)

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to the performance of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated. I, the undersigned, will assume responsibility for fees associated with these procedures.

Signature of Patient _____
(If a minor, parent or guardian must sign)

Signature of Dentist _____ Date _____

MEDICAL HISTORY UPDATE

Date of Update		Patient Signature
_____	❒-same ❒-change	_____
_____	❒-same ❒-change	_____
_____	❒-same ❒-change	_____