FOR OFFICE USE: CHART#_______________

TRINITY DENTAL CENTRE PATIENT INFORMATION FORM (PLEASE PRINT CLEARLY)

Patient Name: Last ___________________________ First _________________________ Preferred to Be Called _________________
Date of Birth (DD/MM/YYYY) ____________________________ **Sex** ☐ Male ☐ Female ☐Prefer not to say
Marital Status ☐Single ☐Married ☐Separated ☐Widowed ☐Other
Address: Street ____ City ______________________ Postal Code ______________
Phone: Home ___________________________ Work _____________________ Mobile __________________________________
E-mail ____
What is your preferred method of contact? ☐Home Phone ☐Work Phone ☐Mobile Phone ☐E-Mail
Occupation _______________________________________
Whom may we thank for referring you to our office? _____________________________________

EMERGENCY CONTACT
Name _________________________________ **Phone #** ___________________ **Relationship to You** _____________________

DENTAL BENEFIT PLAN INFORMATION

PRIMARY PLAN
Insurance Company ________________________________
Employer/School Name ____________________________
Policy Holder Name ________________________________
Policy Holder Date of Birth __________________________
Policy Holder's Relationship to You: (Please check)
☐ Self ☐ Spouse ☐ Parent
Group # ____
ID/Certificate # ____________________________________

SECONDARY PLAN
Insurance Company ________________________________
Employer/School Name ____________________________
Policy Holder Name ________________________________
Policy Holder Date of Birth __________________________
Policy Holder's Relationship to You: (Please check)
☐Self ☐Spouse ☐ Parent
Group # ____
ID/Certificate # ____________________________________

▪ **Have you used the same insurance coverage at other dental offices?** ……………………………..… ☐ YES ☐ NO

MEDICAL HISTORY
Name of Family Physician _____________________________________ **Phone #** _________________________
Address ____

▪ **Are you presently under the care of a physician? If so, what is the condition being treated?**
☐Yes; please specify ____ ☐No
▪ **Do you use any prescription or non-prescription medicine regularly?**
☐Yes; please specify ____ ☐No

Do you currently have, or have you ever had any of the following?

- Allergy
  Please specify:___________
- Arthritis
- Asthma or Hay Fever
- Blood Disorder
  - Anemia
  - Bleeding Tendencies
- Bone Disorder
- Cancer
- Chest Pain
- Diabetes
  Type I Type II
- Drug Addiction
- Eating Disorder
- Epilepsy/Seizures
- Fainting Spells
- Glaucoma
- Heart Attack
- Heart Murmur/Mitral Valve Prolapse
- Hepatitis:
  A B C
- High Blood Pressure
- HIV/AIDS
- Immune Disorder
- Jaundice
- Joint Replacement
- Kidney Disorder
- Liver Disorder
- Low Blood Pressure
- Lung/Breathing Problems
- Mental/Nervous Disorder
- Osteoporosis
- Pacemaker
- Radiation or Chemotherapy
- Rheumatic Fever
- Serious Illness
- Sexually Transmitted Disease
- Stomach/Intestinal Problems
- Stroke
- Surgery – When: _________
- Thyroid
- Tuberculosis (TB)
- Other: ______________________
- Notes: ______________________

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Are you allergic to any of the following? (Please check YES or NO for each one)

Acetaminophen/Tylenol	☐YES	☐NO	Ibuprofen/Advil	☐YES	☐NO
Aspirin	☐YES	☐NO	Latex	☐YES	☐NO
Codeine	☐YES	☐NO	Metals	☐YES	☐NO
Local Anaesthetic (Freezing)	☐YES	☐NO	Penicillin	☐YES	☐NO
Erythromycin	☐YES	☐NO	Sulfa	☐YES	☐NO
Fluoride	☐YES	☐NO	Tetracycline	☐YES	☐NO

- Do you smoke or chew tobacco?
  ☐Yes; How many packs per day? ____________________ For how long? __________________ ☐No

Female Only - Are you pregnant? (Please inform us if you are pregnant/might be pregnant prior to your treatment)
☐Yes, Expected Delivery Date _______________________ ☐No

DENTAL HISTORY

Previous Dentist Name ____________________________________ **Phone #** _________________________

Address ____

- **How frequently do you visit a dentist?**
  ☐3 months ☐ 6 months ☐9 months ☐ Yearly ☐Other_________________
- **Last Dental Visit** _________________ **Last Cleaning** _________________ **Last Full Set of X-rays** _________________
- **Do you have any abnormal growths, swelling, or bleeding in your mouth?** .... ☐YES ☐NO
- **Are you sensitive to objects placed in your mouth?** .... ☐YES ☐NO
- **Have you ever been advised to take antibiotics before a dental appointment?** .... ☐YES ☐NO
- **Cleaning aids presently used:**
  ☐Electric Toothbrush ☐ Floss ☐ Stim-U-Dent® ☐Toothpick ☐Water-flosser/Waterpik®
- **Do you have any emotional concerns regarding your dental visit?**
  ☐Embarrassment ☐ Pain ☐ Fear ☐ Time ☐Financial
- **Have you considered teeth whitening?** .... ☐YES ☐NO

OFFICE POLICY

✓ All fees charged follow the Ontario Dental Association fee guide for the current year.

✓ Payment is required each time service is rendered.

✓ Your appointment time will be reserved specifically for you. We require a two business days' notice in the event of a cancellation. Short notice cancellations (i.e., less than two business days' notice) and missed appointments are subject to a fee of $80 per half hour appointment to cover our expenses.

✓ It is your responsibility to inform Trinity Dental Centre of any changes in your medical status at the earliest possible time.

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

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

Signature of Patient __________________ Date __________________

Signature of Dentist __________________ Date __________________

MEDICAL HISTORY UPDATE

Date of Update			**Patient Signature**
_______________________	SAME	CHANGED	_______________________
_______________________	SAME	CHANGED	_______________________
_______________________	SAME	CHANGED	_______________________