WELCOME TO OUR DENTAL OFFICE

The personal information provided below will be kept private by our office. All information will be used and disclosed responsibly according to the Privacy Act standards set up and monitored by our office.

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Given Name:_____ Marital Status:_____

Surname:_____Pronunciation:_____Prefer to be called:_____

Address: (Street)_____(Apt#)_____(City)_____(Postal Code):_____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ x _____ Date of Birth:_____/_____/_____

Fax: (____) _____ - _____ Other (____) _____- _____ x _____ ☐ Male ☐ Female ☐ Adult ☐ Child

Employer/School: _____ Occupation: _____

eMail Address: _____ Contact Method ☐ EMAIL ☐ PHONE

Who may we thank for referring you to this office? _____

Are you likely to be available on short notice for future appointments? ☐ Yes ☐ No

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name: _____

Relationship: _____

Day-time phone: H _____ W _____

Name of Family Doctor: _____

Phone or address: _____

ASSIGN SIGNATURE

I hereby assign my benefits, payable from claims submitted electronically to Dr. _____ and authorize payment directly to him/her.

This authorization shall continue in effect until the undersigned revokes the same.

_____ _____

Signature of subscriber Date

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(1) Name of medical specialist: _____

Area of specialty: _____

Phone or address: _____

(2) Name of medical specialist: _____

Area of specialty: _____

Phone or address: _____

EDI SIGNATURE

I authorize release to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist.

This authorization shall continue in effect until the undersigned revokes the same.

_____ _____

Signature of patient, parent or guardian Date

Person responsible for this account: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: _____

Name: (Last)_____(First)_____(Initial)_____ Relation:_____

Address: (Street)_____(Apt#)_____(City)_____(Postal Code):_____

Home Phone: (____) ____ - _____ Work Phone: (____) ____ - _____ x _____ _____

Primary Insurance

Subscriber:_____ Date of Birth:_____/_____/_____

Relation: ☐ Self ☐ Spouse ☐ Other:_____

Subscriber I.D._____ SIN_____

Insurance Co: _____

Policy/Plan #: _____ Division/Sect. #: _____

Are you familiar with Your Plan Details? ☐ Yes ☐ No

Method of Payment ☐ Cash ☐ Cheque ☐ Credit Card: _____ Number:_____ Exp.: _____

Secondary Insurance

Subscriber:_____Date of Birth:_____/_____/_____

Relation: ☐ Self ☐ Spouse ☐ Other:_____

Subscriber I.D._____ SIN_____

Insurance Co: _____

Policy/Plan #: _____ Division/Sect. #: _____

Are you familiar with Your Plan Details? ☐ Yes ☐ No

Medical History

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? ☐ Yes ☐ No

_____

2. When was your last medical checkup?_____

3. Has there been any change in your general health in the past year? If yes, please explain. ☐ Yes ☐ No

_____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. ☐ Yes ☐ No

_____

5. Do you have any allergies? If you answered yes, please list using the categories below: ☐ Yes ☐ No

a) medications
b) latex/rubber products
c) other (e.g. hayfever, foods)

_____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. ☐ Yes ☐ No

_____

7. Do you have or have you ever had asthma? ☐ Yes ☐ No
8. Do you have or have you ever had any heart or blood pressure problems? ☐ Yes ☐ No
9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. inefective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ☐ Yes ☐ No
10. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No
11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ Yes ☐ No
12. Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No
13. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No
14. Have you ever been hospitalized for any illness or operations? If yes, please explain. ☐ Yes ☐ No

_____

15. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ rheumatic fever	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)	☐ osteoporosis medications (e.g. Fosamax, Actonel)
☐ heart attack	☐ mitral valve prolapse	☐ lung disease	☐ diabetes	☐ kidney disease	
☐ stroke	☐ heart murmur	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	
☐ shortness of breath	☐ cancer	☐ arthritis	☐ drug/alcohol dependency		

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? ☐ Yes ☐ No

_____

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ Yes ☐ No

_____

18. Do you smoke or chew tobacco products? ☐ Yes ☐ No

19. Are you nervous during dental treatment? ☐ Yes ☐ No

20. **For women only**: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ☐ Yes ☐ No

_____

Dental History

	Yes	No
1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other _____		
Are you presently having dental pain?	☐	☐
Is there a dental problem you would like to take care of as soon as possible?	☐	☐
Please specify: _____		
2. How frequently do you see your dentist? ☐ 6 months ☐ Yearly ☐ Other _____		
Last dental visit: _____		
Last cleaning: _____ Full mouth series of x-rays: _____		
3. How often do you brush your teeth? _____ Floss? _____		
4. Do your gums bleed easily?	☐	☐
5. Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Biting ☐ Sweets?	☐	☐
6. Do you feel you have bad breath at times?	☐	☐
7. Have you ever had jaw joint surgery?	☐	☐
8. Do you have pain in your jaw joints or suffer from migraine headaches?	☐	☐
9. Does any part of your mouth hurt when clenched?	☐	☐
10. Does your jaw crack or pop when opened widely?	☐	☐
11. Have you had: ☐ Braces ☐ Oral surgery ☐ Gum treatment ☐ Root canal	☐	☐
12. Do you grind or clench your teeth during the day or night?	☐	☐
13. Do you smoke? Number per day:	☐	☐
14. Do you or does any family member have a problem with snoring?	☐	☐
15. Have you ever experienced any growths or sore spots in your mouth? If so, where? _____	☐	☐
16. Previous problems with dental treatment? Specify: _____	☐	☐
17. Are you satisfied with the appearance of your teeth?	☐	☐
Please specify: _____		
18. Other Dental Concerns: _____		

Privacy Act Notification: I have been informed of the privacy policy of this office and understand that all information I have supplied will be used and disclosed as set out within this office policy.
Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it may be necessary to charge for time lost.
Patient Release: 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. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependants is mine, and I will assume responsibility for fees associated with these services.

_____ Date: ____M____/____D____/____Y____ _____

(Signature) ☐ Patient ☐ Parent ☐ Guardian Reviewing Dentist