Welcome to Our Dental Office

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. Please fill in the entire form.

PERSONAL INFORMATION

Dr. Mr. Mrs. Miss Ms Name: ____________________

Name you would like to be called: ____________________

SIN #: ____________________ Date of Birth (DD/MM/YYYY): ____________________

Home Tel: ____________________ Office Tel: ____________________ Ext: __________

Address: ____________________ Apt: __________

City: ____________________ Postal Code: ____________________

Occupation: ____________________ Employer: ____________________

Email: ____________________ Physician: ____________________

Previous Dentist: ____________________ Physician's Phone No: ____________________

Why have you decided to change dental offices? ____________________

____

How did you hear about us? ____________________

INSURANCE INFORMATION 1

Name of Insured if different from above: ____________________

Insurance Company: ____________________ Birthdate of Insured (DD/MM/YYYY): ____________________

Division if applicable: ____________________ Policy/Group: ____________________

Employer: ____________________ Certificate ID #: ____________________

Do you have secondary Insurance? ____________________

INSURANCE INFORMATION 2

Name of Insured if different from above: ____________________

Insurance Company: ____________________ Birthdate of Insured (DD/MM/YYYY): ____________________

Division if applicable: ____________________ Policy/Group: ____________________

Employer: ____________________ Certificate ID #: ____________________

EMERGENCY CONTACT

Name: ____________________ Relationship: ____________________ Tel: ____________________

MEDICAL HISTORY

	YES	NO
Are you being treated for any medical condition at the present or have you been treated within the last year?	❑	❑
If yes, specify: ____________________		
When was your last medical check-up? ____________________		
Has there been any change in your general health in the past year?	❑	❑
Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below:	❑	❑

Drug: ____________________ Reason: ____________________

Drug: ____________________ Reason: ____________________

Drug: ____________________ Reason: ____________________

SEE REVERSE

	YES	NO
Do you have any allergies? ❑ Latex ❑ Other: ______	❑	❑
Have you had an unusual reaction to any drugs or medicines? ______	❑	❑
❑ Penicillin ❑ Sulfonamide ❑ Aspirin ❑ Codeine ❑ Local Anesthetic ❑ Other: ______		
Have you ever taken cortisone or steroid medication? ______	❑	❑
Do you have any sinus problems? ______	❑	❑
Do you have or have you ever had any heart problems? ______	❑	❑
Do you have a pacemaker? ______	❑	❑
Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? ______	❑	❑
Do you or have you ever had jaundice, hepatitis or liver disease? ______	❑	❑
Do you have a bleeding problem or bruise easily? ______	❑	❑
Do you have any conditions that could affect your immune system eg. AIDS, HIV infection, Leukemia etc? ______	❑	❑
Do you smoke? If yes, how much? ______	❑	❑
Have you ever been hospitalized for any serious illnesses or operations? ______	❑	❑
Do you have any prosthetic or artificial joints? ______	❑	❑

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

❑ Chest Pain/Angina ❑ Heart Attack ❑ High Blood Pressure ❑ Stroke ❑ Tuberculosis ❑ Arthritis
❑ Emphysema ❑ Epilepsy ❑ Thyroid Disease ❑ Diabetes ❑ Asthma ❑ Stomach Ulcers
❑ Kidney Disease ❑ Cancer ❑ Chemotherapy/Radiation ❑ Psychiatric Disorder ❑ Drug/Alcohol Dependency

	YES	NO
For females: Are you pregnant or breast feeding? ______	❑	❑
Any other conditions or problems of which the dentist should be aware of? ______	❑	❑

If yes, please list: ______

______

DENTAL HISTORY

	YES	NO
When was your last dental visit? ______		
When did you last have dental x-rays? ______		
How often do you brush your teeth? ______		
How often do you floss your teeth? ______		
Have you been seeing a dentist regularly? ______	❑	❑
Do any of your teeth ache? ______	❑	❑
Have you ever been advised to take antibiotics before dental appointments? ______	❑	❑
Do your gums bleed when you brush? ______	❑	❑
Do you have any pain when you chew? ______	❑	❑
Do you feel that you have bad breath? ______	❑	❑
Have you ever been in a motor vehicle accident or experienced any blows to your jaw? ______	❑	❑
Have you ever had a dental implant surgery? ______	❑	❑
If yes, who performed the surgery and when was it done? ______		
Are you being followed-up by a dental specialist? ______	❑	❑

Please list anything else not mentioned above regarding your past dental history: ______

______

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general and local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

______	______	______	______
Signature of patient	D D / M M / Y Y Y Y	Reviewed by dentist	D D / M M / Y Y Y Y