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

Mr. Mrs. Miss. Ms: _____
Name you would like to be called:_____
SIN#_____ Date of Birth (DD/MM/YYYY) _____
Home Tel: _____Office Tel No: _____
Address: _____APT#_____
City_____ Postal Code:_____
Email: _____
Physician: _____ Physician's Phone No
Previous Dentist: _____
How did you hear about us? _____

INSURANCE INFORMATION (1ST)

Name of Insured if different from above: _____
Insurance Co: _____
Birthdate of Insured (DD/MM/YYYY) _____
Division if Applicable _____ Policy/Group _____
Employer: _____ Certificate ID# _____
Do you have secondary insurance?
_____

INSURANCE INFORMATION (2NDARY)

Name of Insured if different from above: _____
Insurance Co: _____
Birthdate of Insured (DD/MM/YYYY) _____
Division if Applicable _____ Policy/Group _____
Employer: _____ Certificate ID#: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Tel No: _____

MEDICAL HISTORY

Are you being treated for any medical condition at the present or have been treated with the last year? YES or NO

If yes, please describe: _____

When was your last medical check-up? _____

Has there been any change in your general health in the past year? YES or NO

Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below:
Drug: _____ Reason: _____
Drug: _____ Reason: _____
Drug: _____ Reason: _____
Do you have any allergies? If yes, please specify _____
Have you had an unusual reaction to any drugs or medicines? YES or NO
Penicillin Sulfonamide Aspirin Codeine Local Anesthetic Other
Have you ever taken cortisone or steroid medications? YES or NO
Do you have any sinus problems? YES or NO
Do you have or have you ever had any heart problems? YES or NO
Do you have a pacemaker? YES or NO
Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? YES or NO
Do you or have you ever had jaundice, hepatitis or liver disease? YES or NO
Do you have a bleeding problem or bruise easily? YES or NO

Do you have any conditions that could affect your immune system? YES or NO

E.g.: Aids, HIV Infection, and 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? _____ YES or NO
Do you have or have you ever had any of the following?
Chest Pain/Angina Heart Attack High Blood Pressure Drug/Alcohol Dependency Tuberculosis Arthritis
Emphysema Epilepsy Thyroid Disease Diabetes Asthma Stroke
Stomach Ulcers Cancer Kidney Disease Psychiatric Disorder Chemo/Radiation
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

When was your last dental visit? _____
When did you last have dental xrays? _____
How often do you brush your teeth? _____
How often do you floss your teeth? _____
Have you been seeing a dentist regularly? _____ YES or NO
Do any of your teeth ache? _____ YES or NO
Have you ever been advised to take antibiotics before dental appointments? _____ YES or NO
Do your gums bleed when you brush? _____ YES or NO
Do you have any pain when you chew? _____ YES or NO
Do you feel that you have bad breath? _____ YES or NO
Have you ever been in a motor vehicle accident or experienced any blows to your jaw? _____ YES or NO
Have you ever had a dental implant surgery? _____ YES or NO
If yes, who performed the implant surgery and when was it done? _____
_____
Are you being followed-up by a dental specialist? _____ YES or NO
If yes, provide the specialist and reason: _____
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 may not be all inclusive.

_____ _____
Signature of Patient Date
(DD/MM/YYYY

Relationship to the Patient: [ ] Self [ ] Parent [ ] Guardian Print Name:

_____ _____
Dentist Signature Date
(DD/MM/YYYY)