Patient Information

Patient Name: _____ _____ ___ _____ Date: _____
Last First MI (Preferred Name)

Birth Date: _____ Gender: (M / F) Family Status: (M / S) SIN #: _____
Day / Month / Year

Phone (Home): _____ (Work): _____ Ext: _____

Employer: _____

Cell Phone: _____ E-Mail: _____

Address: _____
Street

_____
City Province Postal Code

Whom may we thank for referring you to our practice? _____

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies (list below)

_____

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy**

Due date: _____

- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ STD
- ☐ Osteoporosis
- ☐ Penicillin Allergy
- ☐ Codeine Allergy
- ☐ OTHER:

_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

  If yes, please explain: _____

- Are you now under the care of a physician? ☐ Yes ☐ No

  If yes, please explain: _____

- Name of Physician: _____ Phone: _____

- Are you currently taking any medication? ☐ Yes ☐ No

  If yes, please list: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ Date: _____
Signature of patient, parent or guardian

Person Responsible for Account

Name: _____ Phone: _____

Insurance Information

Primary

Name of Insured: _____ _____ ___ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ GR #: _____ ID #: _____
Day / Month / Year

Insurance Company _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child

Coverage % _____ _____ Limit $ _____
Basic Major

Secondary

Name of Insured: _____ _____ ___ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ GR #: _____ ID #: _____
Day / Month / Year

Insurance Company _____ Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child

Coverage % _____ _____ Limit $ _____
Basic Major

Dental History

1. Date of last dental visit: _____ Former Dentist: _____

   Purpose _____

2. Have you had regular dental care (annually) in the past? ☐ Yes ☐ No

3. Do you have any oral habits such as clenching, grinding your teeth, or nail biting? ☐ Yes ☐ No

4. How often do you brush your teeth? _____

5. How often do you floss your teeth? _____

6. Are you satisfied with the function and appearance of your teeth? ☐ Yes ☐ No

7. Have you ever had or do you have any of the following:

☐ Bridge	☐ Extractions	☐ Gum treatments
☐ Partial denture	☐ Loose teeth	☐ Surgeries in your mouth
☐ Full Denture	☐ Orthodontic treatment	☐ Sensitive teeth
☐ Root canal filling	☐ Swelling in your mouth or jaws	☐ Bleeding Gums
☐ Lost fillings	☐ Injuries to your face or jaws	☐ Sores or lumps in mouth

8. What dental condition concerns you now? _____

Electronic Billing / Treatment Authorization

I hereby assign my benefits to the named dentist and authorize payment directly to him / her. I also authorize the communication of information related to coverage between my dental plan carrier and the named dentist.

X _____
Signature of subscriber

Please note that any charges not covered by your dental plan are your responsibility and will be billed to your account.

I, the undersigned, consent to the dental treatment agreed upon and that I am responsible for payment of the corresponding fees. I understand that a possibility of complications exist for each treatment.

X _____ **Date:** _____
Signature of patient, parent or guardian