Patient Information (Confidential)

Last Name ______________________________ First Name: ____________________ □ Dr. □ Mr. □ Mstr. □ Mrs. □ Miss.
Pref. Name ________________ Date of Birth _____________________ Sex: _______________
Address ____________________________________ City _________________________ Prov. __________________
Postal Code _____________________ Home Phone ___________________ Cell Phone ___________________
E-Mail _____________________________________
Consent to confirm appointments by (circle ONE): Text messaging Email Phone call
Occupation __________________________ Employer __________________________ Work Phone _______________
Person to Contact In Case of Emergency _____________________________________Phone _____________________
Relationship to Patient ____
Whom May We Thank For Referring You? ____

Responsible Party (If different from above)

Name ____ Relationship to Patient ____________________
Address________________________________ Home Phone _____________ Work Phone _______________________
Is This Person Currently A Patient In Our Office? □ Yes □ No

Insurance Information

Name of Insured ____ Date of Birth _____________________
Employer___________________________________ Insurance Company___________________________________
Group/Policy # __________ Certificate/I.D. # _______________ Do you have any additional Insurance? □ Yes □ No

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:* ___________________

Medical History

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 check-up? ____
3. Name & Address of Medical Doctor ____
4. Are you taking any medications, non-prescription drugs or herbal supplements? □ Yes □ No
If yes, please list. ____
____
5. Do you have any allergies? If you answered yes, please list using the categories below □ Yes □ No
a) Medications ____
b) Other (e.g. latex, hay fever, foods) ____
6. Have you ever had an adverse reaction to any medicines or injections? □ Yes □ No
If yes, please explain. ____
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. infective endocarditis), a heart condition from birth (congenital heart disease) or a heart transplant? □ Yes □ No
10. Do you have a prosthetic or artificial joint? Since When? _____________________________________ □ 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 illnesses or operations? □ Yes □ No
    If yes, please explain. ____
15. Do you have or have you ever had any of the following? Please check.

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

16. Are there any conditions or diseases not listed above that you have or have had? □ Yes □ No
    If so, what? ____
17. Are there any diseases or medical problems that run in your family? □ Yes □ No
    If so, what? (e.g. diabetes, cancer or heart disease) ____
18. Do you smoke or chew tobacco products? □ Yes □ No
19. For women only: Are you breastfeeding or pregnant? □ Yes □ No
    If pregnant, what is the expected delivery date? ____________________

Dental History

What is your present dental problem? ____

When was your last dental visit? ________________________What was done then? ________________________________

How often did you visit the dentist before then? ____

Previous dentist (Name and Location) ____

Have you had complete series of dental films (x-rays) taken? □Yes □No If yes, when? ____________________________

How often do you brush your teeth? ______________________ How often do you floss your teeth? __________________

Are you nervous during dental treatment? □Yes □No Explain ____

Do your gums bleed when brushing or flossing? □Yes No

Do you have any sores or lumps in your mouth? □Yes No

Are your teeth sensitive to hot, cold or sweet? □Yes □No

Do you bite your lips or cheeks frequently? □Yes □No

Do you feel pain in any of your teeth? □Yes □No

Does food get caught between your teeth? □Yes □No

Do you wear a bite plate or other appliance? □Yes □No

Have you ever had any of the following dental treatment? Please check.

□ Periodontal (Gums) □ Root Canal □ Teeth Whitening □ Orthodontic
□ Crowns or Bridges □ Implants □ Veneers □ Full or Partial Denture

Is there anything you would like to change about your smile? ____

Cancellation Policy

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 2 business days' notice, to avoid a missed appointment charge.

Payment Policy

Our dedicated and experienced administrators will file your insurance electronically, send estimates and help interpreting your insurance coverage. The patient is responsible for payment at the time of treatment, and will be reimbursed by their dental insurance company where applicable.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Signature (Parent/Guardian if patient is a minor) X ______________________________ Date ___________________