PATIENT INFORMATION AND HEALTH HISTORY

Date: _____ Personal Health Care #:_____

Name: _____ M___ F ___ Birthday _____
Last First Month Day Year

Mailing Address _____
Number Street City

Province _____ Postal Code _____ Phone _____Cell #_____ Work _____

Email_____ _____

Can we email or text you to confirm your appointments? Circle one YES NO If yes email only ___ text only ___ both ___
(You can opt out at any time)

KIDS ONLY: Mom's Name _____ Dad's Name_____

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

DENTAL INSURANCE

Primary Insurance

Name of Insured Member _____
Member's birthday _____
Name of Insurance Company _____
Employer _____
Group #_____ID #_____

Secondary Insurance

Name of Insured Member _____
Member's birthday _____
Name of Insurance Company _____
Employer _____
Group #_____ID#_____

MEDICAL HISTORY

Physician_____ Date of last exam _____

Are you allergic to any medications please select below?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Sulfa
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Codeine
- ☐ Sedatives
- ☐ Dental Anesthetic (Epinephrine)
- ☐ Latex
- ☐ Metals
- ☐ Ibuprofen
- ☐ Acetaminophen
- ☐ Other(please list below):

_____

Do you have or have you had any of the following:

- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Infective Endocarditis
- ☐ Cardiac Transplant
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cortisone-Steroid Treatment
- ☐ Diabetes Type I or II
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hemophilia
- ☐ Hepatitis A B C
- ☐ Jaundice
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Fainting
- ☐ Sleep Apnea
- ☐ Tobacco use
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Acid Reflux
- ☐ Head or Neck injury
- ☐ Emphysema
- ☐ Blood Thinning Medication
- ☐ Premedication
- ☐ Vitamins
- ☐ Birth control
- ☐ Dental Anxiety

WOMEN ONLY- Are you possibly pregnant? _____ How Many Weeks? _____

If taking medications, supplements, and / or vitamins, please list below:

_____

_____

Is there any additional information regarding your health we should know about as your dentist?

_____

DENTAL HISTORY

Main dental concern _____

Have you had any previous problems with dental work	☐ Yes ☐ No
Do you have, or have you had bleeding upon brushing or flossing	☐ Yes ☐ No
Do you clench or grind your teeth	☐ Yes ☐ No
Do you have frequent blisters or sores on your lips	☐ Yes ☐ No
Do you ever notice unpleasant taste or bad breath	☐ Yes ☐ No
Do you experience chronic or frequent headaches	☐ Yes ☐ No
Are you happy with your smile	☐ Yes ☐ No

If no, what would you change? _____

EMERGENCY CONTACT INFORMATION

Please list the names and telephone numbers of two relatives or friends that we may contact in case of an emergency.

Name _____ Phone number _____

Name _____ Phone number _____

FINANCIAL POLICY

For your convenience we accept Visa, MasterCard, and Debit. Payment for treatment is due at the time of service rendered.

INSURANCE POLICY

If you have dental benefit coverage, it should be considered as a means of assisting you with the cost of maintaining your oral health, which is connected to your overall health. Since the Privacy Act was introduced in 2004, insurance companies often will not share the details of your plan with us. Our office bills over 50 different insurance companies and policies, each having their own rules and regulations. This will affect benefits paid, deductibles and maximum yearly limits. Please be aware of what your plan limitations are and share them with us. Out of province plans will be handled as reimbursement plans only. If you have any questions our administrative assistants will be happy to assist you.

MISSED APPOINTMENT POLICY

We kindly request 48 hour notice to reschedule an appointment. Same day cancellation, appointments cancelled with less than 48 notice and no show appointments will be subject to a charge of $75.00.

Patient or Parent Signature: _____

Date: _____