SCARBOROUGHDENTAL.CA

Welcome to our Office

In order to render the best professional care, it is necessary to become acquainted with vital information, which is strictly confidential to our office. PLEASE PRINT

PERSONAL INFORMATION

Name ☐ *Mr.* ☐ *Mrs.* ☐ *Miss* ☐ *Ms.* _____ *Age* _____
Date of Birth M___D___Y____ *Address*_____ *City*_____ *Postal Code*_____
Home Phone _____ *Bus Phone* _____ *Cell Phone* _____
Email Address _____

Employer _____ *Occupation* _____

Dental Insurance *Yes* *No* *(please circle)*

*Insurance Company*_____ *Who's Plan/ Subscriber's Name* _____ *DOB*_____
Group Plan # _____ *ID/ Certificate #*_____

Do you have a Secondary Insurance Plan? *Yes* *No* *(please circle)*
*Insurance Company*_____ *Who's Plan/ Subscriber's Name* _____ *DOB*_____
Group Plan # _____ *ID/ Certificate #*_____ *Employer* _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Family Physician _____ *Phone #*_____
Are you under medical treatment presently? *Yes* *No (If so, specify)* _____

Please CIRCLE below if you have or have had any of the following:

Artificial Bones/Joints	*Hear Attack/ Stroke*	*Diabetes*
Panic Attacks	*Heart Catheter/ stints*	*Hypoglycemia*
ADD/ADHD	*Angina/ chest pain*	*Seizures/ Epilepsy*
Hearing/vision loss	*Pacemaker*	*Asthma*
Handicaps/ Disabilities	*High or Low Blood Pressure*	*Emphysema*
Addiction to drugs/Alcohol	*Cancer (type)* _____	*Allergies/ Sinus problems*
AIDS/0ARC/HIV	*Chemotherapy/Radiation*	*Ulcers*
Hepatitis/Liver Problems	*Bleeding problems/Anemia*	*Stomach/Intestinal Problems*
Tuberculosis	*Thyroid Disease*	*Kidney Problems/Dialysis*
Rheumatic Fever	*Osteoporosis*	*Shingles/ Herpes*

Do you smoke? *Yes* *No*

Women: *Are you pregnant?* *Yes* *No* *If so, due date* _____ *Are you nursing?* _____

Allergy or Adverse reaction to: *Penicillin/ Amoxicillin* *Aspirin* *Codeine* *Sulpha*
Latex *Tetracycline* *Local anesthetics*
Other Drugs _____

Do you have any problems or allergies not listed above? If so, please describe.

_____

_____

Please list all your medications. Include all prescription and over the counter medications (herbal medications, pain relievers, vitamins) Please note what the medication is taken for.

_____

_____

Do you wish to speak with the doctor privately about any problem or medical condition? _____

DENTAL HISTORY

Date of your last visit? _____ *last dental cleaning?* _____ *Name of Dentist* _____
Reason for your visit today? (please circle)

Examination Filling Tooth removal Consultation Cleaning
Other _____
Are you having discomfort or pain? _____
Do you have prolonged bleeding following extractions? _____
Would you like to improve the cosmetic appearance of your teeth? _____
Does food catch between your teeth? _____
Have you ever been advised to take antibiotics before your dental appointment? _____
Have you ever had an upsetting experience in a dental office? _____

Do you presently think you have any of the following? (please circle)
Loose teeth cavities gum disease sensitive teeth sore jaw head aches ear aches
bleeding gums unsightly/broken filling abscessed teeth bad breath dry mouth

Would you be interested in having Nitrous Oxide (laughing gas) during appointments? _____

OFFICE POLICY

Fees in our office are based on the current Ontario Dental Association fee guide. Payment for treatment is due at the time of completion of each appointment. For your convenience, cheques may be post dated up to 30 days. We accept Visa, Mastercard, Debit and Cash.

I understand that I am responsible for payments of dental services for myself and my dependants, and I assume responsibility for fees associated with these services.

_____ _____
Patient or Guardian signature *Date*

I the undersigned, certify that all information provided is true to the best of my knowledge. I have not omitted any pertinent information. If there should be a change in my health, I am to inform the Doctors and/or staff immediately.

_____ _____
Patient or Guardian Signature *Date*