PATIENT CODE

ACQUAINTANCE INFORMATION

ACCOUNT CODE

The data on this confidential form is essential if we are to render the best professional care. We appreciate your co-operation in filling it out carefully so that we will have accurate records. **Please print - Thank you.**

PERSONAL INFORMATION

PATIENT'S LAST NAME (Mr., Mrs., Ms. Dr.)	FIRST NAME	MIDDLE	HOME PHONE

HOME ADDRESS	CITY/TOWN	POSTAL CODE

DATE OF BIRTH M D Y	OCCUPATION	MARITAL STATUS	BUSINESS PHONE

EMAIL	PREFERRED CONTACT ☐ EMAIL ☐ CELL ☐ WORK ☐ HOME	CELL PHONE #

☐ BY CHECKING THIS BOX, I AGREE TO RECEIVE EMAIL COMMUNICATION FROM OUR OFFICE.	BY WHO WERE YOU REFERRED
WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT?	IN CASE OF EMERGENCY NOTIFY RELATIONSHIP PHONE #

INSURANCE INFORMATION/IF YOU HAVE A DENTAL PLAN PLEASE COMPLETE THE FOLLOWING

NAME OF INSURANCE COMPANY	IS PARTNER UNDER ANOTHER PLAN ❑ Yes ❑ No

IF COVERDED UNDER PARTNER'S PLAN AS SECONDARY COVERAGE, PLEASE PROVIDE COMPANY NAME

MEDICAL HISTORY

PHYSICIAN	ADDRESS	PHONE

Are you currently under medical treatment? If so, for what: _____

Have you had an allergic or unusual reaction to: **(Please circle your answer to each question. If yes, please explain.)**

Aspirin	Yes	No		Cosmetics	Yes	No	
Codeine	Yes	No		Metals	Yes	No	
Dental Anaesthetic	Yes	No		Other Medicines	Yes	No	
Penicillin	Yes	No		Women: Are you pregnant?	Yes	No	Expected Date of Delivery

Have you ever been treated for any of the following:

AIDS/HIV	Yes	No	Glaucoma	Yes	No	Pain In The Chest	Yes	No
Anaemia	Yes	No	Hay Fever	Yes	No	Persistent Cough	Yes	No
Anorexia or Bulimia	Yes	No	Heart Attack	Yes	No	Rheumatic Fever	Yes	No
Arthritis	Yes	No	Heart Defects	Yes	No	Rheumatoid Arthritis	Yes	No
Asthma	Yes	No	Heart Murmurs	Yes	No	Shortness Of Breath	Yes	No
Bleeding Problems	Yes	No	Heart Trouble	Yes	No	Seizures	Yes	No
Blood Disorders/Problems	Yes	No	Hemophilia	Yes	No	Sinus Trouble	Yes	No
Bowel Problems	Yes	No	Hepatitis A, B or C (Liver Disease)	Yes	No	Skin Disorder	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Coughing Up Blood	Yes	No	Jaundice	Yes	No	Thyroid Problems	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No	Tuberculosis	Yes	No
Drug or Alcohol Dependency	Yes	No	Leukemia	Yes	No	Ulcer	Yes	No
Emphysema	Yes	No	Liver Problems	Yes	No	Venereal Disease	Yes	No
Epilepsy	Yes	No	Lung Disease	Yes	No	Sleep Apnea	Yes	No
Gastrointestinal Disorders	Yes	No	Lupus	Yes	No	Other	Yes	No
			Mitral Valve Prolapse	Yes	No			

Do you have a pacemaker? ..... Yes No If yes, please give details:

1. Have you ever been hospitalized or had a serious illness or had any surgery? ..... Yes No
2. Are you or have you received any psychiatric care and are you receiving medication for this? ..... Yes No
3. Are you being treated for any condition by a physician? ..... Yes No
   A. presently? Yes ❑ No ❑
   B. in the last 2 years Yes ❑ No ❑
4. Have you taken any drugs, pills, medicines or tablets in the last 2 years up to and including the present? .... Yes No
5. Do you ever have asthma, hayfever, hives, skin rash? ..... Yes No
6. Have you ever had an adverse reaction to any drug including local anaesthetic (freezing) or general anaesthetic? Yes No
7. Are you allergic to latex? ..... Yes No
8. Do you have any other allergies? ..... Yes No
9. Have you had any unexplained weight loss, increasing thirst or appetite or increase in frequency of urination? Yes No
10. Have you ever taken cortisone? ..... Yes No
11. Do you bleed for a prolonged period of time when cut? ..... Yes No
12. Do you have any problems with healing when cut or bruised? ..... Yes No
13. Is there any history of disease in your family? ..... Yes No
14. Have you ever fainted? ..... Yes No
15. Is there anything that the dentist should know about your medical history that has not been mentioned? ..... Yes No
16. Are you pregnant or nursing? ..... Yes No
17. Are you presently taking any drugs or medicines? **(please circle)** ..... Yes No

Antibiotics or sulfa drugs	Drugs for heart trouble	Sedatives or sleeping pills
Anticoagulants (blood thinners)	High blood pressure medicine	Tranquilizers
Antidepressants	Insulin, Diabinese or similar drug	Water pills
Cortisone	Nitroglycerin	High Cholesterol Other

18. Have you had any joint replacements? ..... Yes No

19. Have you ever or are you now receiving radiation therapy or chemotherapy? ..... Yes No _____
20. Do you have any in-dwelling catheters? ..... Yes No _____
21. Have you ever taken appetite supressant drugs, for example fenfluramine, phenteremine or dexfenfluramine? Yes No _____
22. Do you smoke? If so, how much. _____
23. Have we missed anything? _____

_____

Patient's Signature _____ Medical history taken by _____ Date _____

DENTAL HISTORY

PREVIOUS DENTIST	ADDRESS	DATE OF LAST VISIT	PHONE

1. When was your last dental visit? _____
2. How often do you have a dental check-up? _____
3. Have you ever had an unfavourable experience at the dentist? ..... Yes No _____
4. Do you have any discomfort in your teeth due to hot, cold, sweets, biting or chewing pressure? ..... Yes No _____
5. Does food catch between your teeth? _____ If so, where? _____
6. Do your gums bleed when brushing or flossing? ..... Yes No _____
7. Are you conscious of bad breath or bad taste in your mouth? ..... Yes No _____
8. Do you favour one side when chewing? ..... Yes No _____
9. Are you unhappy with the appearance of your teeth, bite or smile? ..... Yes No _____
10. If you could, would you change anything about your smile? ..... Yes No _____
11. Do you consider your teeth beyond repair? ..... Yes No _____
12. Do you ever wake up with a headache or have a tired feeling in your face or jaws? ..... Yes No _____
13. Do your jaw joints pop, click or grate when opening widely? ..... Yes No _____
14. Do you clench or grind your teeth? ..... Yes No
15. Have you lost any teeth due to abscess, accident, decay or gum disease? **(please circle)** ..... Yes No
16. Was tooth replacement suggested? ..... Yes No

Please review your medical history on the other side. Indicate whether there is any change in your medical status, or if you are taking any new medications. Please indicate any changes below, with date and your signature.

1. _____ 2. _____

_____ _____

DATE SIGNATURE DATE SIGNATURE

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED CONSENT TO THE PERFORMING OF DENTAL AND ORAL SURGERY PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE INCLUDING THE USE OF LOCAL ANAESTHETIC AND/OR RELATIVE ANALGESIA AS INDICATED, AND I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

I HEREBY AUTHORIZE THE RELEASE OF INFORMATION CONTAINED TO DENTAL CLAIMS AND/OR TREATMENT PLANS TO BE SUBMITTED ELECTRONICALLY, THROUGH CDANET TO MY INSURANCE COMPANY PLAN ADMINISTRATOR.

ALL TREATMENT AND CARE DECISIONS SHOULD BE MADE BY YOU AND YOUR DENTIST BASED ON YOUR ACTUAL NEEDS, ASIDE FROM YOUR DENTAL PLAN COVERAGE. YOUR DENTAL PLAN IS NOT NECESSARILY A TREATMENT PLAN. THE ONTARIO DENTAL ASSOCIATION PROVIDES A SUGGESTED FEE GUIDE THAT IS UPDATED ANNUALLY AND IS INTENDED TO SERVE ONLY AS A REFERENCE FOR FEES, SOME OF OUR FEES MAY BE ABOVE THE CURRENT SUGGESTED FEE GUIDE.

_____ _____

PATIENT'S (PARENT'S, GUARDIAN'S) SIGNATURE DATE