WELCOME TO OUR DENTAL OFFICE

(For Office Use Only)

MEDICAL ALERT	

Date:____________________

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form. PLEASE PRINT.

REGISTRATION INFORMATION

The patient is an: ADULT ❑ CHILD ❑ ADULT UNDER GUARDIANSHIP ❑ Name of Guardian: ____________

Name:____________________
(last) (first) (initials) (preferred first name)

Address:____________________
(street) (apt -#) (city) (province) (Postal Code)

Reason for today's visit? Examination ❑ Emergency ❑ Other ____________

E-mail address:____________ May we call you at work? ____________

Home Phone: ( ) ____________ Driver's Lic. No.: ____________ Health Card No.:____________

Cell Phone: ( ) ____________ Ext. ______ Employer:____________ Occupation: ____________

PERSONAL INFORMATION

Date of Birth: ___ ___ ___ Age:______ Sex:______ Marital Status: ____________ Name of Spouse: ____________
D M Y

Are other family member's patients at our office?____________

Whom may we thank for referring you to us? ____________

DENTAL INSURANCE

Name of person responsible for your account ❑ Self, Other:			Do you have Dental Insurance? Yes No	
Do you have Secondary Dental Insurance? Yes No ☐	Name of Insured Employee		Insurance Company	Secondary Insurance Company
	Group Policy Number		Certificate or I.D. Number	
Policy Holder Date of Birth D_____ /M _____ /Y_____			Secondary Policy Holder Date of Birth D_____ /M _____ / Y _____	
Family Physician	Phone		Previous Dentist	Current Dentist
Pharmacy				
In case of emergency notify		Relationship		Phone

MEDICAL HISTORY

	Yes	No
Is your physician currently treating you for any reason?	❑	❑
If yes, explain ____________		
Do you presently take a multi-vitamin daily?	❑	❑
Have you ever been hospitalized?	❑	❑
If yes, specify ____________		
Have you ever had a general anesthetic?	❑	❑
Have you ever had a reaction to local DENTAL ANAESTHETIC?	❑	❑
Do you bruise easily or bleed excessively when cut?	❑	❑
Are you currently taking any pills, drugs or other medicines?	❑	❑
If yes, please list: 1. ____________ 2. ____________ 3. ____________ 4. ____________		
Have you ever taken cortisone, steroids, anti-depressants, blood thinners, or thyroid medicine?	❑	❑
Do you smoke tobacco products?	❑	❑

(Over)

MEDICAL HISTORY

Please check if you have had any of the following:

- ❑ Heart disease or chest
- ❑ High blood pressure
- ❑ Heart murmur
- ❑ Pacemaker or artificial valves
- ❑ Rheumatic fever
- ❑ Diabetes
- ❑ Blood disorders or anemia
- ❑ Lung or breathing
- ❑ Asthma
- ❑ Kidney or liver problems
- ❑ Hepatitis (A B or C)
- ❑ Thyroid problems
- ❑ Stomach or intestinal problems
- ❑ Tuberculosis
- ❑ Arthritis
- ❑ Artificial joint replacements
- ❑ Epilepsy or seizures
- ❑ Syphilis, gonorrhea, AIDS
- ❑ Tumors or cancer
- ❑ Radiation therapy
- ❑ Shortness of breath

Please specify: ____

____

	Yes	No
Do you currently have, or have you had in the past, any disease, condition or problem not listed above?	❑	❑
Is there anything else concerning your health the doctor should know?	❑	❑
Do you take aspirin daily?	❑	❑
Are you allergic to any medications or drugs?	❑	❑
If yes, explain ______________________		
Do you have any other allergies?	❑	❑
If yes, to what?______________________		
WOMEN ONLY: Are you pregnant or suspect you may be? If yes, when do you expect?__________	❑	❑
Are you taking birth control pills?	❑	❑

OFFICE PHILOSOPHY & POLICY (please read)

In an effort to determine a treatment plan that is best for your overall dental health, we must make a careful diagnosis. This involves a thorough examination, often utilizing the minimum number of X-rays necessary for accuracy.

We pledge to provide high quality dentistry in the most comfortable manner possible, with the best equipment, materials and up to date techniques. The long-term success of our efforts will depend on the patient's willingness to maintain their teeth and prevent any future dental problems.

Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we require 48 hours' notice.

Our office policy is that services are paid for at each visit as they are performed. In certain circumstances, financial arrangements for payment may be made by consulting the doctor or receptionist.

Any outstanding balances that are sent to collection, the patient assumes all collection costs involved.

Regarding Insurance: All patients with dental insurance are responsible for paying their own accounts. We are pleased that you have insurance to reimburse or minimize your personal expenditure and we will gladly complete any claim forms to assist you in collecting your dental benefits. Please make certain you understand any 'limitations in your contract. We will gladly submit 'estimate' forms, if necessary.

All urgent dental problems will be attended to the same day, under normal circumstances. You may call our office or answering service at any time. A healthy dentist-patient relationship is based on mutual respect and understanding. Please feel relaxed and open to discuss with us, any aspect of your treatment or fees, at any time, otherwise we will assume you understand.

CONSENT FOR TREATMENT .This is to certify that I consent to the performing of the dental procedures agreed to be necessary and I will assume responsibility for fees associated with those procedures. I have read the office philosophy and policy and understand its contents.

Date: ______________________ Signature: ______________________