

Name: _____ Today's date: _____
Last First middle initial day / month / year

Birthdate: _____ Male Female Married Single Child Other _____
day / month / year

Phone (home): _____ (work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: Anytime Morning Afternoon Evening M T W Th F S

Address: _____
Apartment # - Street
City Province Postal Code

E-mail address: _____

Employer Name: _____ Occupation: _____

Referring or previous dentist: Dr. _____ Phone: _____

Family physician: Dr. _____ Phone: _____

Emergency contact: _____ Phone: _____

Whom may we thank for referring you to our practice?

Another patient Yellow Pages Newspaper Ad Work School Other _____

Name of person referring you to our practice: _____

Do you have or have you ever had any of the following? Please those that apply.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Fainting | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Growths | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Artificial Joints/Valves | <input type="checkbox"/> Head Injuries | Due date: _____ | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever | OTHER: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hi/Lo Blood Pressure | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> H.I.V. | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> NONE OF THE ABOVE |
| | <input type="checkbox"/> Liver Disease | | |

• Are you currently taking any medication? Yes No

If yes, please explain or list medication(s): _____

• Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Are you a smoker? Yes No

If yes, how much do you smoke and for how many years have you been a smoker? _____

• Do you have any health problems (including unusual drug reactions) that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct and I have not knowingly omitted data. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____
day / month / year

Spouse or Responsible Party Information

Name: _____
Last First middle initial

Birthdate: _____ Male Female Married Single Other _____
day / month / year

Phone (home): _____ (work): _____ Ext: _____ Best time to call: _____

Address: _____
Apartment # - Street

City Province Postal Code

E-mail address: _____

Employer Name: _____ Occupation: _____

Dental Information

Date of last dental visit: _____ Date of last dental x-rays: _____ Past frequency: ____/yr

Reason for today's visit: _____

I brush my teeth _____ times per day week. I floss my teeth _____ times per day week.

My teeth are sensitive to cold heat sweets chewing/biting other: _____

My gums bleed when brushing flossing never

I have had my wisdom teeth extracted yes no (If yes, how many have been extracted? _____)

I would like to improve my smile. yes no

I would like to make my teeth whiter. yes no

The most important part of dentistry to me is _____

Consent for Treatment & Cancellation Guidelines

All dental services (including emergency treatment) must be paid for at the time the services are performed. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for the payment of all dental services.

We will help prepare insurance claim forms and assist in requesting reimbursements from insurance companies on behalf of the patient. Not all services may be covered by dental insurance and every plan has its own unique quirks and exceptions. It is the patient's responsibility to understand his or her own dental insurance benefits.

We require a minimum of 24 hours notice (1 business day) if an appointment must be cancelled or rescheduled.

No charge will be made for cancelled appointments provided 24 hours (one business day) notice is given. **If less than 24 hours notice is given to cancel or reschedule an appointment, or if a patient does not show up for a scheduled appointment, a \$ 100.00 fee will be charged.** Please note that insurance companies do not cover fees for broken appointments. Therefore such fees are the patient's responsibility.

I authorize the dentist or his staff to perform all dental or diagnostic procedures agreed to be necessary or advisable, including x-rays, photographs, and the use of local anesthetic or other medications as indicated. I understand that if I miss an appointment or provide less than 24 hours notice to cancel or reschedule an appointment, I will be charged a cancellation fee of \$100. I assume full responsibility for fees associated with my dental treatment and those of my dependents. I have read and fully understand the above conditions of treatment and I accept my responsibilities as a patient at this office.

Signature of patient, parent or guardian

Date: _____
day / month / year