



YOUR BEST DENTAL EXPERIENCE

## New Patient Form

### Patient Information

First Name : \_\_\_\_\_ Middle Name : \_\_\_\_\_ Last Name : \_\_\_\_\_

Address : \_\_\_\_\_ City : \_\_\_\_\_

Province : \_\_\_\_\_ Postalcode : \_\_\_\_\_

Date of Birth : \_\_\_\_\_ Home Phone : \_\_\_\_\_

Work Phon : \_\_\_\_\_ Cell Phone : \_\_\_\_\_

Email Address : \_\_\_\_\_

Preferred Contact Method : Phone  Email

Emergency Contact : \_\_\_\_\_ Emergency Contact Phone : \_\_\_\_\_

Family Doctor : \_\_\_\_\_ Family Doctor Phone : \_\_\_\_\_

Previous Dentist : \_\_\_\_\_

Referred By : Another Patient  Yellow Pages  Google  Other

### Financial Information

Person Responsible For Financial Matters : \_\_\_\_\_

Do you have dental coverage? : Yes  No

### Primary

Policy Holder Name : \_\_\_\_\_ Date Of Birth : \_\_\_\_\_

Insurance Company : \_\_\_\_\_ Policy/Group# : \_\_\_\_\_ Id : \_\_\_\_\_

## Secondary

Policy Holder Name : \_\_\_\_\_ Date Of Birth : \_\_\_\_\_

Insurance Company : \_\_\_\_\_ Policy/Group# : \_\_\_\_\_ Id : \_\_\_\_\_

## Medical History

1. Are you presently under the care of a physician? YES  NO

Explain : \_\_\_\_\_

2. Have you ever been hospitalized? YES  NO

Explain : \_\_\_\_\_

3. Are you taking any drugs or medication at this time?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Have you ever had any adverse effect to any of the following

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Penicillin Antibiotic  | <input type="checkbox"/> Aspirin                       | <input type="checkbox"/> Darvon            |
| <input type="checkbox"/> Sulfonamide Antibiotic | <input type="checkbox"/> Barbiturates (sleeping pills) | <input type="checkbox"/> Local Anaesthetic |
| <input type="checkbox"/> Other Antibiotic       | <input type="checkbox"/> Codeine                       | <input type="checkbox"/> None              |

5. Have you ever been warned against using any other medications? YES  NO

Which: \_\_\_\_\_

6. Have you ever taken prolonged medical or non-medical drugs? YES  NO

Which: \_\_\_\_\_

7. Do you suffer from any allergies (hay fever, latex etc.) YES  NO

Which: \_\_\_\_\_

8. Do you bruise easily or have prolonged bleeding? YES  NO

9. Do you smoke ? YES  NO

How much per day? : \_\_\_\_\_

10. Have you ever fainted, had shortness of breath or chest pains? YES  NO

10.a) Do you use Marijuana? If yes, how often? \_\_\_\_\_ YES NO

10. b) Do you take weight loss medications? If yes, please list: \_\_\_\_\_ YES NO

11. WOMEN:

Are you pregnant? : YES  NO

Using birth control? : YES  NO

Reached menopause? : YES  NO

12. Do you have or have you ever had any of the followings? Please select appropriate boxes.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> None                    | <input type="checkbox"/> Angina pectoris             | <input type="checkbox"/> Arthritis/rheumatism            |
| <input type="checkbox"/> Blood disorders         | <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Cortisone/steroid               |
| <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Heart murmur                    |
| <input type="checkbox"/> Hepatitis A/B/C         | <input type="checkbox"/> H.I.V. Positive             | <input type="checkbox"/> Hypertension                    |
| <input type="checkbox"/> Liver disease           | <input type="checkbox"/> Malignant hypothermia       | <input type="checkbox"/> Organ transplant/implant        |
| <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> Stomach/intestinal problems | <input type="checkbox"/> Tuberculosis                    |
| <input type="checkbox"/> A.I.D.S.                | <input type="checkbox"/> Anorexia nervosa            | <input type="checkbox"/> Artificial Joints (hips, knees) |
| <input type="checkbox"/> Bronchitis              | <input type="checkbox"/> Circulation Problems        | <input type="checkbox"/> Diabetes                        |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Head/Neck Injuries          | <input type="checkbox"/> Heart Pacemaker/Surgery         |
| <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Hodgkin's Disease           | <input type="checkbox"/> Jaundice                        |
| <input type="checkbox"/> Leukemia                | <input type="checkbox"/> Mental/Nervous Disorder     | <input type="checkbox"/> Psychiatric Disorders           |
| <input type="checkbox"/> Sickle Cell Disease     | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Ulcers                          |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Artifical Heart valve       | <input type="checkbox"/> Asthma                          |
| <input type="checkbox"/> Bulimia                 | <input type="checkbox"/> Congenital heart lesions    | <input type="checkbox"/> Drug/alcohol dependence         |
| <input type="checkbox"/> Glandular Disorders     | <input type="checkbox"/> Heart disease/attack        | <input type="checkbox"/> Heart rhythm disorder           |
| <input type="checkbox"/> High/Low Blood pressure | <input type="checkbox"/> Hyper(Hypo) Glycemia        | <input type="checkbox"/> Kidney disease                  |
| <input type="checkbox"/> Lung disease            | <input type="checkbox"/> Mitral valve prolapse       | <input type="checkbox"/> Radiation/Chemotherapy          |
| <input type="checkbox"/> Sinus trouble           | <input type="checkbox"/> Thyroid disease             | <input type="checkbox"/> Venereal diseases               |
| Other  | Other  | Other  |

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13. CHILDREN Have you recently had any of the following (approximate date):

- Chicken Pox                       Mumps                       Tonsillitis  
 MeaslesDate                       Strep Throat                       None

## Dental History

1. What is the reason for today's visit?

- Emergency                       Examination                       Other : \_\_\_\_\_

2. How frequently do you see dentist?

- 3-6 Months                       Annually                       Other : \_\_\_\_\_

3. When was your last dental visit? :

Last X-Ray?

\_\_\_\_\_

4. How often do you brush per day?

Floss?

Use Antibacterial rinse?

\_\_\_\_\_

5. Are your teeth sensitive to?

- Cold                       Sweets                       Heat                       No                       Other sensitivity? : \_\_\_\_\_

6. Do your gum bleed when :  Brushing                       Flossing                       Never

7. Do your gums feel swollen or tender?

YES                       NO

8. Do you have bad breath or a bad taste in your mouth?

YES                       NO

9. Do your jaws crack, pop or grate when you open widely?

YES                       NO

10. Do you grind or clench your teeth?

YES                       NO

11. Do you have food catch between your teeth?

YES                       NO

12. Have you ever had local anaesthetic (freezing)?

YES                       NO

Any complication with Anaesthetic (freezing)?

YES                       NO

Specify : \_\_\_\_\_

13. Have you ever had any problems with previous dental treatments?

YES                       NO

Specify : \_\_\_\_\_

14. Have you ever had any of the following :

- Bridge Work                       Crowns or Caps                       Full or Partial Dentures  
 Orthodontic (braces)                       Periodontal (Gums)                       Root Canal

15. Are you satisfied with your teeth?

YES  NO

Specify : \_\_\_\_\_

## General Release

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have no knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment.

I understand that if I miss an appointment or provide less than 48 hours( 2 days)notice to cancel or reschedule an appointment, I will be charged a cancellation fee.Please note that insurance companies do not cover fees for missed/canceled appointments. Therefore, it will be patient's responsibility to pay such fees.

I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment of dental diagnostic procedures.We will assist you in preparing insurance claim forms, along with requesting reimbursements from your insurance company, on your behalf. Be aware that not all services may be covered by your insurance company, no two plans are the same. We will work with you to help clarify your plan. However, it is the responsibility of the patient to understand his or her own dental insurance benefits. Services are to be paid for at each visit as they are performed.

I have read and fully understand the above terms and conditions and I accept my responsibility as a patient at this office.

Signed By :  Self  Parent/Guardian

Your Signature

\_\_\_\_\_

Print Name : \_\_\_\_\_ Date : \_\_\_\_\_