WELCOME TO OUR PRACTICE !

Name: _____ _____ _____ _____
First Middle Last Preferred name

Address: _____
City Province/State Postal Code

Date of Birth: _____ Sex: M ☐ F ☐ Marital Status: _____
m d y

Home Phone: _____ Work Phone: _____ Cell Phone: _____

e-mail address: _____

PREFERRED METHOD OF CONTACT: e-mail ☐ cell phone ☐ home phone ☐ work ☐

Occupation: _____ Employer: _____

How did you hear about us? ☐ Ad ☐ Walk-by ☐ Website ☐ Facebook ☐ family or friend

Referred by: _____

Are you happy with your smile? Yes ☐ No ☐
If not, what would you like to change? _____
Are you interested in any cosmetic procedures: Botox ☐ veneers ☐ Invisalign ☐

DENTAL INSURANCE

❑ None

Primary Dental Insurance

Policy Holder's Name _____
Relationship to patient _____
Date of Birth: _____
Insurance Company Name _____
Group / Policy # _____
Division # _____
ID / Certificate # _____

Secondary Dental Insurance

Policy Holder's Name _____
Relationship to patient _____
Date of Birth: _____
Insurance Company Name _____
Group / Policy # _____
Division # _____
ID / Certificate # _____

Consent for Treatment and Office Policies

I hereby consent to the performing of the dental and oral surgical procedures agreed to be necessary and advisable, with the use of local anaesthetic when indicated. I am aware that I am responsible for full payment of fees for services provided, unless prior arrangements have been made, and will be responsible for any insurance reimbursements. As a courtesy to you, our office will send all applicable claims on your behalf to your dental insurance plan, and I will assume full responsibility for fees associated with any procedures not covered by my plan.

I am aware that there may be a charge of $50.00 per hour for any missed appointments or appointment changes/ cancellations with less than 24 business hours notice.

Patient/Parent/Guardian: _____ Date: _____
(signature)

_____
(print name)

Dental Health History

Patient Name: _____ _____ _____ Today's Date: _____
First Middle Last

Date of Birth: _____

DENTAL HISTORY

Reason for Today's Visit: _____
Former Dentist: _____ Address: _____
Date of Last Dental Care: _____ Date of Last X-Rays: _____
Check if you have or had any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Painful Jaw
- ☐ Food Collecting Between Teeth
- ☐ Nightguard
- ☐ Clenching or Grinding Teeth
- ☐ Loose or Broken Teeth or Fillings
- ☐ Periodontal/Gum Treatment
- ☐ Sensitivity to cold, hot, touch, or pressure
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Sores in your mouth
- ☐ Wisdom teeth
- ☐ Orthodontics

Cosmetic/esthetic issues:

- ☐ Tooth whitening
- ☐ Veneers
- ☐ Crowns
- ☐ Bonding

How many times per day do you brush? _____ Floss? _____
Type of toothbrush:_____ Toothpaste: _____
Mouthrinses: _____ Other cleaning aids: _____

MEDICAL HISTORY

Physician's Name: _____ Phone #: _____

(Women): Pregnant? ☐Yes ☐No Due Date: _____ Nursing? ☐Yes ☐No

Check if you have, or have had in the past, any of the following:

- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Haemophilia
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Lung Disease

- ☐ Smoking / Amount: _____
- ☐ Other: _____

MEDICATIONS

Please list the medications you are taking:

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local anaesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Sleeping pills
- ☐ Other:_____ _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Parent/Guardian: _____ Date: _____
(signature)

_____
(print name)