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 text

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	Secondary Dental Insurance
Policy Holder's Name ______________________	Policy Holder's Name ______________________
Relationship to patient ______________________	Relationship to patient ______________________
Date of Birth: ____________________________	Date of Birth: ____________________________
Insurance Company Name__________________	Insurance Company Name__________________
Group / Policy # __________________________	Group / Policy # __________________________
Division # ______________________________	Division # ______________________________
ID / Certificate # __________________________	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 $75.00 per hour for any missed appointments or appointment changes/cancellations with less than 48 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
- ❑ HIV/AIDS
- ❑ Heart Murmur
- ❑ Pacemaker
- ❑ Mitral Valve Prolapse
- ❑ Haemophilia
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Rheumatic Fever
- ❑ Hepatitis
- ❑ Lung Disease
- ❑ Smoking / Amount: ____
- ❑ Other:

MEDICATIONS

Please list the medications you are taking:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

ALLERGIES

- ❑ Aspirin
- ❑ Penicillin
- ❑ Barbiturates
- ❑ Sulfa
- ❑ Codeine
- ❑ Sleeping pills
- ❑ Local anaesthetic
- ❑ 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)