Welcome to our office

In order to render the best professional care it is necessary that we become acquainted with the vital information related to each patient. All information is strictly confidential. We appreciate your co-operation in filling out this form carefully and accurately. (PLEASE PRINT, Thank you.)

Patient's Last Name	Mr. Mrs. Dr. Ms.	Given Names	Home Phone
Apt. / Address		City	Postal Code
Date of Birth month — day — year	Preferred Name	Cell Phone	
E-Mail Address	Employer	Business Phone	
In case of emergency, notify	Relationship	Phone	
Name of person responsible for your account ☐ Self, Other:	Whom may we thank for referring you? Name:		
Do you have Dental Insurance?	Name of Insured Employee	Insurance Company	Employer
	Group Policy Number	Certificate or I.D. Number	
Policy Holder Date of Birth			
Family Physician	Phone	Previous Dentist	Address or Phone

MEDICAL HISTORY

		Yes	No
1.	Is your physician currently treating you for any reason? If yes, explain _____	☐	☐
2.	Have you ever been hospitalized? If yes, specify _____	☐	☐
3.	Do you bruise easily or bleed excessively when cut?	☐	☐
4.	Are you currently taking any pills, drugs or other medicines? If yes, please list 1. _____ 2. _____ 3. _____ 4. _____	☐	☐
5.	Have you ever taken cortisone, steroids, anti-depressants, blood thinners, or thyroid medicine?	☐	☐
7.	Do you smoke tobacco products?	☐	☐
8.	Women Only: Are you pregnant? If yes, when do you expect? _____		

9. Do you have any or have you ever had any of the following?

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

Please specify _____

_____

10.	Is there anything else concerning your health that the doctor should know? _____	☐	☐
11.	Are you allergic to any medication or drugs? If yes, explain _____	☐	☐

DENTAL HISTORY

1. Approximate date of last dental checkup? _____

2. Have you ever had any of the following:

☐ Fillings	☐ Periodontics (gum treatment)	☐ Full or partial dentures
☐ Regular cleanings	☐ Caps or crowns	☐ Orthodontics (braces)
☐ Recent dental X-rays	☐ Extractions	☐ An injury to your mouth or jaws
☐ Nitrous oxide (laughing gas)	☐ Root canal treatment	

	Yes	No
3. Have you ever had an 'unfavourable' dental experience?	☐	☐
If yes, explain? _____		
4. Would you like to improve the general cosmetic appearance of your teeth?	☐	☐
5. Would you like to maintain and keep your natural teeth for a lifetime?	☐	☐

6. Do you presently have or think you may have any of the following:

☐ Loose teeth	☐ Bleeding gums	☐ Unsightly or broken fillings
☐ Cavities	☐ A bad taste in your mouth	☐ Dead or abscessed teeth
☐ Gum disease	☐ A clicking or sore jaw	
☐ Sensitive teeth	☐ Earaches or headaches	

OFFICE PHILOSOPHY AND 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 a prescribed number of X-rays necessary for accuracy.

The longterm 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 specially for you. If you are unable to keep the appointment, we require 1 business days notice.

Our office policy is that services are paid for at each visit as they are performed.

Regarding insurance: All patients with dental insurance are responsible for payment of 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, based on the information you provide. Please make certain you understand any limitations in your contract. We will gladly submit 'estimate' forms, if necessary.

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 of fees, at any time.

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.

_____ _____

Date Signature (Parent or Guardian)

QUESTIONNAIRE UPDATE

1. Date _____ Notes _____
2. Date _____ Notes _____
3. Date _____ Notes _____
4. Date _____ Notes _____
5. Date _____ Notes _____
6. Date _____ Notes _____
7. Date _____ Notes _____
8. Date _____ Notes _____
9. Date _____ Notes _____
10. Date _____ Notes _____
11. Date _____ Notes _____
12. Date _____ Notes _____
13. Date _____ Notes _____

We are pleased to welcome you to our practice and hope to provide you, your friends and relatives with the highest quality of dental care.