

**Welcome to our dental practice! We appreciate the opportunity to help you with your dental needs. Providing this information helps us to treat you safely and efficiently. All information provided is confidential.**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Birthdate (dd/mm/yyyy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postal Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_ **RESPONSIBLE PARENT/GUARDIAN (If patient is a minor):**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **EMERGENCY CONTACT** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PRIMARY INSURANCE INFORMATION (If applicable)**

Name of policyholder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth of policyholder (dd/mm/yyyy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Place of employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Relationship of patient to policy holder: Self / Spouse / Dependent

**SECONDARY INSURANCE INFORMATION (If applicable)**Name of policyholder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth of policyholder (dd/mm/yyyy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of employment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

Relationship of patient to policy holder: Self / Spouse / Dependent

 **\*Please hand insurance card(s) to receptionist at this point.\*

Preferred method of contact to book appointments:**

O Phone O Email
Who may we thank for referring you to our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referrals are always appreciated!

Payment is due on treatment date if not covered by your insurance plan. Overdue accounts are subject to a 1.75% charge per month (minimum charge of $5 per month). I agree to cover any and all collect costs, if necessary.
 Insurance plans are confidential agreement between you and your insurance company. Written estimates can be provided to assist in processing of your dental benefits. You are responsible for any amount not covered by your dental plan.
 I certify that the medical information provided on the following form is accurate and correct to the best of my knowledge.

I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described, to the named dentist.

Our office wants to assist you and all our patients by minimizing wait times between appointments. Last minute cancellations or no shows delay your treatment and the treatment for other patients who could have used that appointment time. **We require 48 hours notice to cancel or reschedule an appointment to avoid a $40.00 cancellation fee**.
 I consent to the release of information as set out in our privacy policy.

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

Signature of patient, parent or guardian Date

 **The following information is required for our dental professionals to provide you with the safest possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. Please fill in the form as completely as possible. The dentist will review the questions and explain any questions that you do not understand**

1. Are you currently being treated for any medical condition at the present, or within the past year? Yes / No

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

1. When was your last medical checkup?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	1. Was there any specific findings?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Name of your Medical Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	3. Medical Doctor’s phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you currently taking any medications, non-prescription drugs, or herbal supplements?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
If yes, please list pharmacy:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any allergies? Use the following categories:

Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Latex/rubber/metals: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (hayfever, foods, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do any of these allergies lead to breathing problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you have any reactions to dental injections? Yes / No
3. Do you have, or ever had asthma? Yes / No
4. Do you have emphysema, bronchitis, or COPD? Yes / No
5. Do you have, or ever had blood pressure problems? Yes / No
6. Do you have, or ever had any chest pain? Yes / No
7. Any history of heart valve replacement or repair? Yes / No
8. Have you ever had total joint replacement? Yes / No
9. Have you ever had a heart attack in the past? Yes / No
10. Have you ever had a stroke in the past? Yes / No
11. Do you have a pacemaker inserted? Yes / No
12. Do you have, or ever had leukemia? Yes / No
13. Do you have, or ever had HIVS or AIDS? Yes / No
14. Do you have, or have ever had hepatitis? Yes / No
15. Do you have, or ever had cancer? Yes / No
16. Do you have, or ever had radiation therapy? Yes / No
17. Do you have, or ever had chemotherapy? Yes / No
18. Do you have, or ever had osteoporosis? Yes / No
19. Have you taken bisphosphonate medications? Yes / No
20. Have you taken any medications to strengthen bones? Yes / No
21. Are you currently taking any steroid therapy? Yes / No
22. Do you have a bleeding disorder? Yes / No
23. Have you ever been diagnosed with diabetes? Yes / No
24. Do you have, or ever had kidney disease or transplant? Yes / No
25. Do you have, or ever had stomach ulcers? Yes / No
26. Do you have, or ever had a seizure before? Yes / No
27. Do you have, or ever had tuberculosis? Yes / No
28. Have you ever been hospitalized for any reason (include year)?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
29. Do you smoke or chew tobacco? Yes / No
30. Do you have, or ever had drug/alcohol dependency? Yes / No
31. Are you nervous during dental treatment? Yes / No
32. Date of last dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
33. Any other medical concerns not listed above?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
34. For women only:
	1. Are you currently pregnant? Yes / No
	2. Are you currently breastfeeding? Yes / No
	3. Are you currently taking an oral contraceptive? Yes / No