Petras FAMILY DENTAL

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_____

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 _____

Policy No_____Subscriber ID number _____

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 _____

Policy No_____Subscriber ID number _____

Place of employment_____

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

Preferred method of contact to book appointments:

☐ Phone ☐ 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). Patient is to cover costs of collection, 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 ☐

   _____

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

   _____

   If yes, please list pharmacy:

   _____
4. Do you have any allergies? Use the following categories:
   Medications: _____
   Latex/rubber/metals: _____
   Other (hayfever, foods, etc.) _____
   a. Do any of these allergies lead to breathing problems?

   _____

5. Do you have any reactions to dental injections? ☐ Yes / No ☐
6. Do you have, or ever had asthma? ☐ Yes / No ☐
7. Do you have emphysema, bronchitis, or COPD? ☐ Yes / No ☐
8. Do you have, or ever had blood pressure problems? ☐ Yes / No ☐
9. Do you have, or ever had any chest pain? ☐ Yes / No ☐
10. Any history of heart valve replacement or repair? ☐ Yes / No ☐
11. Have you ever had total joint replacement? ☐ Yes / No ☐
12. Have you ever had a heart attack in the past? ☐ Yes / No ☐
13. Have you ever had a stroke in the past? ☐ Yes / No ☐
14. Do you have a pacemaker inserted? ☐ Yes / No ☐
15. Do you have, or ever had leukemia? ☐ Yes / No ☐
16. Do you have, or ever had HIVS or AIDS? ☐ Yes / No ☐
17. Do you have, or have ever had hepatitis? ☐ Yes / No ☐
18. Do you have, or ever had cancer? ☐ Yes / No ☐
19. Do you have, or ever had radiation therapy? ☐ Yes / No ☐
20. Do you have, or ever had chemotherapy? ☐ Yes / No ☐
21. Do you have, or ever had osteoporosis? ☐ Yes / No ☐
22. Have you ever taken bisphosphonate medications? ☐ Yes / No ☐
23. Are you currently taking any steroid therapy? ☐ Yes / No ☐
24. Do you have a bleeding disorder? ☐ Yes / No ☐
25. Have you ever been diagnosed with diabetes? ☐ Yes / No ☐
26. Do you have, or ever had kidney disease or transpla☐ Yes / No ☐
27. Do you have, or ever had stomach ulcers? ☐ Yes / No ☐
28. Do you have, or ever had a seizure before? ☐ Yes / No ☐
29. Do you have, or ever had tuberculosis? ☐ Yes / No ☐
30. Have you ever been hospitalized for any reason (include year)?

    _____

    _____

    _____

31. Do you smoke or chew tobacco? ☐ Yes / No ☐
32. Do you have, or ever had drug/alcohol dependency? ☐ Yes / No ☐
33. Are you nervous during dental treatment? ☐ Yes / No ☐
34. Date of last dental treatment? _____
35. Name of previous dentist?_____

36. For women only:
    a. Are you currently pregnant? ☐ Yes / No ☐
    b. Are you currently breastfeeding? ☐ Yes / No ☐
    c. Are you currently taking an oral contraceptiv☐ Yes / No ☐
37. Any other medical concerns not listed above?_____