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Your medical and dental health history are essential for the determination and course of your treatment in our office. It is important that you complete this questionnaire accurately as it will become part of your office record. Be assured that it will be held in the strictest of confidence.

## Welcome to our Office

Today's Date \_\_\_\_\_

Have you been a previous patient here? Yes  No

Please print clearly

Dr.  Mrs.  Mr.  Ms.  Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle Initial \_\_\_\_ Birth Date (Y/M/D) \_\_/\_\_/\_\_

Home Address \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Tel. Number: ( ) \_\_\_\_\_ Business Tel. Number: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Email \_\_\_\_\_

Do you have dental insurance? YES  NO

Name of Spouse/Parent \_\_\_\_\_ Business Tel. ( ) \_\_\_\_\_

Referring Dentist \_\_\_\_\_ Other Dentists you see \_\_\_\_\_

Family Physician \_\_\_\_\_ Tel. Number: ( ) \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

### HEALTH HISTORY

(PLEASE CIRCLE)

Please circle how you are feeling. I am: RELAXED NERVOUS TERRIFIED

Have you ever had an unfavourable reaction following dental treatment? Please discuss this with the doctor. YES NO

Female patients, are you or could you be pregnant or nursing? If pregnant, which month? YES NO

#### Check any of the following which you have or have had:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart trouble/Angina | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Stomach ulcer                          |
| <input type="checkbox"/> Heart murmur         | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Kidney disease                         |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Fainting spells                        |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Lupus                   | <input type="checkbox"/> Sinus trouble                          |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Nervous disorders       | <input type="checkbox"/> Neck injury                            |
| <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Cortisone treatment     | <input type="checkbox"/> Cancer treatment                       |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Psychiatric treatment   | <input type="checkbox"/> Sickle cell disease                    |
| <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Migraine/Headaches      | <input type="checkbox"/> Liver disease                          |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Thyroid disease                        |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Alcoholism                             |
| <input type="checkbox"/> Hepatitis A          | <input type="checkbox"/> Hepatitis B             | <input type="checkbox"/> Mitral valve prolapse                  |
| <input type="checkbox"/> Addictions           | <input type="checkbox"/> Venereal disease        | <input type="checkbox"/> Artificial valve, joint, or prosthesis |
| <input type="checkbox"/> Dementia             | <input type="checkbox"/> Osteoporosis            |   |
| <input type="checkbox"/> TMJ problems         | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Blood transfusions                     |
| <input type="checkbox"/> HIV +/-AIDS          | <input type="checkbox"/> Cardiac pacemaker       | <input type="checkbox"/> Tuberculosis (TB)                      |

Do you have or have you had any other diseases or medical problems not listed on this form? \_\_\_\_\_

Please list allergies to medications/other substances \_\_\_\_\_

Please list medications currently being taken (include non-prescription drugs) \_\_\_\_\_

### DENTAL HISTORY

Chief Complaint (reason for presentation) \_\_\_\_\_

Are you presently in pain? YES  NO

Are any of your teeth sensitive to the following?

- Hot  Cold  Biting Pressure  
 Sweets  Other \_\_\_\_\_

I would like to discuss options of sedation for my dental treatment

YES  NO

I hereby state that the above medical history is, to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs or other diagnostic measures appropriate for a thorough evaluation.

**Financial Policy:** The major objective of our office is to provide you with the highest quality dental care. Our service is based on a friendly, mutual, but businesslike understanding between doctor and patient. We feel that misunderstandings can be minimized if financial policies are made to acquaint you with our policy.

If you have any questions regarding insurance, billing or financial policy feel free to discuss this with our receptionist.

**Our fee does not include the cost of a permanent restoration – to be done by your own dentist after your root canal has been completed.**

Broken appointments and surgical intervention may constitute an additional fee. All fees are payable upon completion of treatment

\_\_\_\_\_  
 Signature

Date

See reverse

To Dr. \_\_\_\_\_

### PRIVACY CONSENT

I consent to your collection, of any and all personal information about me including my personal health information, and all personal information about any minor of whom I have joint or sole parental custody, and to use such information in any manner or for any purpose whatsoever, but only in the course, of, concerning, or relation to, your dental practice.

I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Professions, the Dentistry, and Dental Hygiene Acts of Ontario, and to any insurer or other payment organization who may be responsible for payment of all or a part of any treatment or service you provide.

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

### INSURANCE INFORMATION

Electronic Claims Submission saves you the effort and cost of mailing the insurance from yourself - we provide this service for you. As well, your claims processor will be able to process your claim faster, which means that you will receive your cheque in a more timely fashion than before. Unfortunately, not all insurance companies are currently accepting claims submitted electronically. Some will likely be joining the system in future. In order to submit claims electronically, we require insurance information that you may not have on file. Please complete this form and return it to us as soon as possible. Thank you.

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

Name of Policy Holder: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

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

Policy No.: \_\_\_\_\_

Certificate or Subscriber I.D. No.: \_\_\_\_\_

Relationship of patient to policy holder:  Dependent  Spouse

I authorize release, to my dental benefits plan administrator, information contained in electronically submitted claims.

\_\_\_\_\_

Signature of patient, parent, or guardian

\_\_\_\_\_

Date