ENDODONTIC SOLUTIONS

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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:

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

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