Welcome to Dentistry at DiPietro

Patient Information:

Name _____

Address: _____

City _____ Province_____ Postal Code _____

Gender: _____ Date of Birth: _____

Home phone: _____ Mobile phone: _____

Work: _____ Email: _____

Emergency Contact: _____ Tel: _____

Whom may we thank for referring you to our office? _____

FINANCIAL INFORMATION:

Method of Payment (circle): Cash Cheque Credit Card Insurance Other

Person Responsible for Financial Matters (circle): Self Spouse Parent/Guardian Other

(If other than Self) Name: _____

Address: _____

Date of Birth: _____ Home Tel: _____ Cell: _____

Insurance Information	Primary Insurance	Secondary Insurance
Name of Policy Holder		
Insurance Company		
Company of Employment		
Policy Number		
Certificate Number		
ID Number		

I authorize the dentist to collect the insurance payment for my treatment directly, on my behalf(circle): Yes No

General Consent Statement: I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me and I have had the chance to ask questions and receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical questions. I authorize the dentist to perform the necessary diagnostic procedures and treatment including local anesthetic, as required to achieve proper level of dental care. I understand that I am financially responsible to the dentist for dental services provided even if my insurance coverage may not be all inclusive. I agree that your office collect, use and disclose personal information about me as set out in your privacy policy.

Signature Full Name Date

Patient Medical History

Physician_____ Office Phone_____ Date of Last Exam_____

Are you under a physician now?	Yes	No	Please Explain _____
Have you recently been hospitalized?	Yes	No	Please Explain _____
Are you taking any medications, pills, or drugs?	Yes	No	Please Explain _____
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Women: Are you:

Pregnant? Yes / No Taking oral contraceptives? Yes / No Nursing? Yes / No

Are you allergic to any of the following? (circle)

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex

Other Please Explain _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Emphysema	Liver Disease
Alzheimer's Disease	Epilepsy or Seizures	Lung Disease
Anaphylaxis	Excessive Bleeding	Osteoporosis
Anemia	Fainting Spells/Dizziness	Parathyroid Disease
Angina	Frequent Headaches	Renal Dialysis
Arthritis/Gout	Genital Herpes	Rheumatic Fever
Artificial Heart Valve	Glaucoma	Scarlet Fever
Artificial Joint	Heart Attack/Failure	Sickle Cell Disease
Blood Disease	Heart Murmur	Spina Bifida
Breathing Problem	Heart Pacemaker	Stomach/Intestinal Disease
Bruise Easily	Heart Trouble/Disease	Stroke
Cancer	Hepatitis	Tuberculosis
Chemotherapy	High/Low Blood Pressure	Tumors or Growths
Chest Pains	High Cholesterol	Ulcers
Congenital Heart Disorder	Hypoglycemia	Venereal Disease
Diabetes	Kidney Problems	

Previous Dental History

Do your gums bleed while brushing or flossing?	Yes	No
Are your teeth sensitive to hot or cold liquids/foods?	Yes	No
Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No
Do you have any sores or lumps in or near your mouth?	Yes	No
Have you had any head, neck or jaw injuries?	Yes	No
Do you bite your lips or cheeks frequently?	Yes	No
Have you ever had any difficult extractions in the past?	Yes	No
Do you have frequent headaches?	Yes	No
Do you clench or grind your teeth?	Yes	No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.