## ABOUT YOU

Name:______________________________________________
Last First Initial

I prefer to be called:____________________________

☐ Male ☐ Female Birth Date: ______________________
Day Month Year

Home Address: ________________________________
City, Province: ________________________________
Postal Code: __________________________________
Home Phone: __________________________________
Work/Mobile Phone: ____________________________
Email Address: ________________________________
Employer: ____________________________________
Occupation: __________________________________
Previous Dentist: ______________________________
Last visit there: ______________________________
Emergency Contact:_____________________________
Emergency Phone: _____________________________

Person responsible for account: ☐ Self ☐ Other

If 'Other' please state Name, Phone Number and Relation to self:___________________________________________

_______________________________________________

Who may we thank for referring you?:

_______________________________________________

## DENTAL INSURANCE ☐ Yes ☐ No

Please note that Dental Insurance represents a contract between you and an insurance company with terms negotiated by your employer or union representative. We are happy to help you process claims for dental work and make inquiries on your behalf. However, we are not responsible for knowing the details of your policy and what it covers. Please ask questions – we are always pleased to help you understand your benefits. Any balances not covered by your policy will be billed to you directly. **If you have insurance, please provide this information to the reception desk before your appointment.**

## DENTAL HISTORY

Reason for today's visit:__________________________
Date of last dental x-rays: _________________________

Please check if you have had any of the following:

☐ Bad breath ☐ Grinding teeth
☐ Bleeding Gums ☐ Loose teeth or broken fillings
☐ Jaw Pain ☐ Periodontal treatment
☐ Sensitive teeth ☐ Serious problems with dental work

# Dr. Monica Katyal

1951A Weston Road Toronto, ON M9N 1W8
Ph: (416) 247-8673

## MEDICAL HISTORY

Physician's Name: ______________________________
Phone Number: ________________________________

Your current health is: ☐ Good ☐ Fair ☐ Poor

Have you had any of the following diseases or medical problems?

☐ Yes ☐ No Asthma
☐ Yes ☐ No Anemia
☐ Yes ☐ No Abnormal Bleeding/Hemophilia
☐ Yes ☐ No Cancer Where: ________________
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Epilepsy/Seizures
☐ Yes ☐ No AIDS/HIV/Venereal Disease
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Psychiatric Care
☐ Yes ☐ No Tobacco Habit
☐ Yes ☐ No Ulcers/Colitis
☐ Yes ☐ No Gastro-Intestinal Problems
☐ Yes ☐ No High/Low Blood Pressure
☐ Yes ☐ No Liver Problems
☐ Yes ☐ No Kidney Problems
☐ Yes ☐ No Lung Problems
☐ Yes ☐ No Sinus Troubles
☐ Yes ☐ No Thyroid Disorder Hyper / Hypo
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Heart Problems
☐ Attack / Stroke
☐ Heart Surgery
☐ Heart Murmurs
☐ Mitral Valve Prolapse
☐ Congenital Heart Defects
☐ Rheumatic Fever
☐ Artificial Heart Valves

☐ Yes ☐ No Are you taking any medication?
Please list: ______________________
___________________________________
___________________________________

☐ Yes ☐ No Do you have any allergies?
Please list: ______________________
___________________________________
___________________________________

## AUTHORIZATION AND RELEASE

I understand that the information that I have given is accurate to the best of my knowledge and that this information will be held in the strictest confidence. It is my responsibility to inform this office of changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature: ______________________________
Date: ______________________________