NORTH STAR DENTISTRY

NEW PATIENT AND MEDICAL HISTORY FORM

PATIENT INFORMATION

First Name _____ Last Name _____ Nickname_____
Address _____ City _____Postal Code _____
Phone (home) _____ (cell) _____ Sex ❑ Male ❑ Female ❑ Other
Birth Date M___D___Y____ Marital Status: ❑ Married ❑ Single
Emergency Contact _____Phone _____
Family Physician _____ Phone _____
How did you hear about us? ❑Google ❑Social Media Ads ❑Passing By ❑Word of Mouth ❑ Other: _____

FINANCIAL INFORMATION

Method of payment: ❑ Cash ❑ Cheque ❑ Credit Card ❑ Insurance
Primary Insurance: Company_____ Policy #_____ Member ID _____
Secondary Insurance: Company_____ Policy #_____ Member ID _____
Insured Party _____Relationship to you _____
Insurance year end _____ Maximum annual coverage _____ Deductible _____
% coverage for: Basic_____ Major _____ Preventive_____ Orthodontic_____

DENTAL HISTORY

Reason for today's visit? _____ When was your last dental visit? _____
How often do you brush your teeth? _____ floss? _____ Do your gums bleed? ❑ yes ❑ no.
Are your teeth sensitive? _____ ❑ cold ❑ hot ❑sweets ❑ biting
Do you have ad breath or bad taste in your mouth? ❑ yes ❑ no.
Do you grind/ clench your teeth? ❑ yes ❑ no ❑ not sure.
Do your jaws pop, click or grate when you open widely? ❑ yes ❑ no ❑ sometimes.
Do you have a food catch between your teeth? ❑ yes ❑ no
Have you had local anaesthetic (freezing) before? ❑ yes ❑ no Any complications?
Do you occasionally have ulcers/ cold sores? ❑ yes ❑ no
Have you had any of the following: -
❑ Dentures ❑ crowns ❑ bridges ❑root canals ❑ braces ❑ gum surgery ❑Botox ❑ fillers
Do you have dental phobia? ❑ yes ❑ no.

MEDICAL HISTORY

- Are you under the care of a specialist? ❑ No ❑ Yes. If yes, for what? _____
- Are you taking any prescription medication now? ❑ No ❑ Yes. If yes, please indicate the names, dose and reasons for medication _____
- Do you have allergies to any medication or substance? _____
- Do you bruise easily? ❑ yes ❑ no. Do you take aspirin? ❑ yes ❑ no.
- Do you smoke? ❑ yes ❑ no. Do you drink alcohol? ❑ yes ❑ no. Recreational drugs? ❑ yes ❑ no.
- Women Are you: Pregnant? ❑ Yes ❑ No - Nursing? ❑Yes ❑No - Taking Birth Control Pills? Yes □ No □

Please indicate if you have any of the below: -

- ❑ Heart Disease
- ❑ Stomach Ulcers
- ❑ Diabetes
- ❑ Thyroid
- ❑ Glaucoma
- ❑ Blood disorder
- ❑ Respiratory disease
- ❑ Asthma
- ❑ Chronic sinusitis
- ❑ Radiation Therapy
- ❑ Chemotherapy
- ❑ Tumors / cancer
- ❑ High Blood Pressure
- ❑ Artificial Heart Valve
- ❑ Mitral Valve Prolapse
- ❑ Heart Pacemaker
- ❑ Rheumatic Fever
- ❑ Arthritis/Rheumatism
- ❑ Stroke
- ❑ Artificial Joint (hip, knee)
- ❑ Liver Disease
- ❑ Head/Spine injuries
- ❑ Leukemia
- ❑ A.I.D.S/ HIV
- ❑ Hemophilia
- ❑ Neurological Disorders
- ❑ Epilepsy or Seizures
- ❑ Fainting or Dizzy Spells
- ❑ Psychiatric care
- ❑ Kidney Disease
- ❑ Hepatitis /Jaundice

APPOINTMENTS

When you book an appointment with us, we reserve that time specifically for you to see the dentist or hygienist. As such, we require 48 hours' notice in the event an appointment must be cancelled. This allows other patients awaiting treatment to be rescheduled into the time slot initially reserved for you.

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by the dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

I consent to the collection, use and disclosure of my personal information as set out above:

Patient Name: _____Signature _____ Date (mm/dd/yyyy) _____

Verified by Dr. _____ Signature_____ Date (mm/dd/yyyy) _____