SCUGOG DENTAL

Welcome

Patient Information

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you.

A parent or guardian will be responsible for decisions on my treatment ☐ YES ☐ NO

Name: _____
First Initial Last Nickname

Address: _____

Date of Birth: _____ Email: _____

Home #: _____ Cell#: _____ Work #: _____

Prefer contact via : ☐ Home# ☐ Cell# ☐ Work# ☐ Email

Driver's License#: _____ Ontario Health Card #: _____

Emergency contact: _____ Tel#: _____

Family Doctor: _____ Tel#: _____

How did you hear about us? _____

Financial Information

Method of payment: ☐ Cash ☐ Credit Card ☐ Insurance ☐ Other

Person Responsible for financial matters: ☐ Self ☐ Parent Gurardian ☐ Spouse ☐ Other

IF DIFFERENT FROM ABOVE

Name: _____
First Initial Last

Address _____
Street Apt. City Prov. Postal Code

Date of Birth: _____ Cell#: _____ Work#: _____

PRIMARY INSURANCE

Employer: _____
Policy Holder Name: _____
Date of Birth: _____
Insurance Company: _____
Policy: _____ **Certificate:** _____

SECONDARY INSURANCE

Employer: _____
Policy Holder Name: _____
Date of Birth: _____
Insurance Company: _____
Policy: _____ **Certificate:** _____

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 this dental office. I authorize the 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 dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures. I hereby certify that I have been notified of the privacy policies of this office, who to contact regarding privacy concerns and how to request further information.

_____ _____ _____

Signature Self Parent/Guardian **Print name** **Date**

Medical History (This information will remain confidential) Date: _____ Yes No

1. Are you presently under the care of a physcian? If so, explain _____ ☐ ☐
2. Have you ever been hospitalized? Explain _____ ☐ ☐
3. Are you taking any drugs or medication a this time? _____ ☐ ☐
   A) Drug _____ Reason _____
   B) Drug _____ Reason _____
   C) Drug _____ Reason _____
4. Have you ever had any adverse effect to any of the following: **Antibiotic**-Penicillin☐, Sulfonamide☐, Other☐; Aspirin☐; **Barbiturates** (sleeping pills) ☐; **Codeine**☐; **Darvon**☐; **Local Anesthetic**☐; **NONE**☐.
5. Have you ever been warned against using any other medications? Which? _____ ☐ ☐
6. Have you ever taken prolonged medical or non medical drugs? Which? _____ ☐ ☐
7. Do you suffer from any allergies (hay fever, latex etc.)? Which? _____ ☐ ☐
8. Do you bruise easily or have prolonged bleeding? _____ ☐ ☐
9. Do you smoke? How much per day? _____ ☐ ☐
10. Have you ever fainted, had shortness of breath or chest pains? _____ ☐ ☐
11. **WOMEN ONLY:** Are you pregnant? Yes ☐No☐ Using birth control? Yes☐ No☐ Reached menopause? Yes ☐No ☐
12. Do you have or have you ever had any of the following? Please check appropriate boxes.

☐ A.I.D.S.	☐ Cancer	☐ Heart disease/attack	☐ Jaundice	☐ Rheumatic/Scarlet fever
☐ Anemia	☐ Circulation problems	☐ Heart Murmur	☐ Kidney disease	☐ Sickle Cell disease
☐ Angina pectoris	☐ Congenital Heart lesions	☐ Heart pacemaker/surgery	☐ Liver disease	☐ Sinus trouble
☐ Anorexia nervosa	☐ Cortsone/steroid	☐ Heart rhythm disorder	☐ Leukemia	☐ Stomach/Intesinal problems
☐ Artificial Heart Valve	☐ Diabetes	☐ Hepatitis A/B/C	☐ Jaundice	☐ Rhumatic/Scarlet fever
☐ Arthritis/rheumatism	☐ Drug/alcohol dependence	☐ Herpes	☐ Malignant hypothermia	☐ Throid disease
☐ Artifical joints(hips, knees)	☐ Emphysema	☐ High/Low Blood pressure	☐ Mental nervous disorder	☐ Tuberculosis
☐ Asthma	☐ Epilepsy	☐ H.IV. Positive	☐ Miltral valve prolapse	☐ Ulcers
☐ Blood disorders	☐ Glandular disorders	☐ Hodgkin disease	☐ Organ transplant/implant	☐ Venereal disease
☐ Bronchitis	☐ Glaucoma	☐ Hyper (Hypo) Glycemia	☐ Psychiatric disorders	☐ Other _____
☐ Bulimia	☐ Head/Neck Injuries	☐ Hypertension	☐ Radiation/Chemotherapy	☐ NONE

13. **CHILDREN ONLY:** Have you recently had any of the following (approximate date)?
    ☐ Chicken Pox ☐ Measles ☐ Mumps
    ☐ Strep Throat ☐ Tonsilillitis ☐ NONE

Dental History

1. What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other .....
2. How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Other .....
3. When was you last dental visit? ☐ Last X-ray?
4. How often do you brush per day? ☐ 1x ☐ 2x ☐ Floss? ☐ Use anti-bacterial rinse?
5. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other
6. Do your gums bleed when: Brushing Flossing Never ..... Yes ☐ No ☐
7. Do your gums feel swollen or tender? ..... ☐ ☐
8. Do you have bad breath or a bad taste n your mouth? ..... ☐ ☐
9. Do your jaws crack, pop or grate when you open widely? ..... ☐ ☐
10. Do you grind or clench your teeth? ..... ☐ ☐
11. Do you have food catch between your teeth? ☐ ☐
12. Have you ever had local anaesthetic (freezing)? Any complications? Specify
13. Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps ☐ Full or Partial Dentures
    Orthodontic (braces) Periodontal (gums) Root Canal
14. Are you satisfied with your teeth? Specify ..... ☐ ☐