Oaktree Dental Centre

Patient Information

Patient Name: _____ _____ _____ Date:_____
Last First MI

☐ Male ☐ Female / ☐ Married ☐ Single ☐ Child ☐ Other_____ Parent/Guard. Name:_____

Birth Date: (dd/mm/year) _____Email:_____

Phone (Home): _____ (Cell): _____ Preferred method of contact: Home ☐ Cell ☐

Address: _____
Street

_____
City Province Postal Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- _____
- _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☑ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ **Date:**_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Flyer ☐ Website ☐ Other_____

Name of person or office referring you to our practice:_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City Province Postal Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: (dd/mm/year) _____ ID #: _____ Group #:_____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: (dd/mm/year) _____ ID #: _____ Group #:_____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

I ACKNOWLEDGE MY RESPONSIBILITY TO PAY THE CO-PAYMENT _____
Signature of patient, parent, or guardian

Consent for Services

Welcome to our dental office. Our office will make sure that we look after your dental needs and give you the best treatment that will give you a healthy mouth.

AS CONSIDERATION OUR OFFICE REQUIRES 2 BUSINESS DAYS FOR ALL CANCELLATIONS OR CHANGES.

I will allow your office to send my insurance information over the internet to my insurance company. I will be responsible to pay for services rendered on the day of treatment unless special arrangements have been made.

Our office takes the Privacy Act very seriously and will make sure to follow proper protocols set in place.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date:** _____ **Relationship to Patient:** _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party