RIVER NORTH DENTAL

Dr. Marc Thevenot, DMD, B.Sc.
Dr. Amanda Finch, DMD, B.Sc.

Patient Information

Last Name: _____ First Name: _____

Preferred Name: _____ Preferred Pronoun: _____

Gender: ☐ Male ☐ Female ☐ Other

Date of Birth (DD/MM/YYYY): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Employer: _____ Occupation: _____

How did you hear about our office? _____

Insurance Information

If you are unsure of anything in this section, our receptionists are happy to help!

Do you have dental insurance? ☐ Yes ☐ No

Do you have coverage through alternative programs such as NIHB, EIA, Worker's Compensation, MPI, or any other program?

☐ Yes ☐ No

If so, please specify and provide ID or claim reference number: _____

Primary Insurance Provider:

Name of Policy Holder: _____

Relationship to Policy Holder: _____

Date of Birth (DD/MM/YYY): _____

Insurance Company: _____

Group/Policy/Plan #: _____

Certificate/ID #: _____

Secondary Insurance Provider:

Name of Policy Holder: _____

Relationship to Policy Holder: _____

Date of Birth (DD/MM/YYY): _____

Insurance Company: _____

Group/Policy/Plan #: _____

Certificate/ID #: _____

Medical History

Name of Family Doctor: _____ Date of Last Exam: _____

Please List Any Prescriptions or Medications That You Take Regularly: _____

_____

Are you sensitive or allergic to any medications or medical products (ie: latex)? ☐ Yes ☐ No

If so, please specify: _____

Please check any/all that apply:

- ☐ Heart Disease/Condition
- ☐ Pacemaker/Defibrillator
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Asthma
- ☐ History of Rheumatic Fever
- ☐ Anemia
- ☐ Diabetes: Type 1 or 2?
- ☐ Epilepsy/Seizures
- ☐ Tonsil, Adenoid, Sinus Problems
- ☐ Autoimmune Disease
- ☐ Gastric Reflux
- ☐ Alzheimer's/Dementia
- ☐ Pregnant or Breastfeeding
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Fainting/Dizzy Spells

Please list any other medical conditions, allergies, or other things we should know regarding your medical history: _____

_____

_____

Do you have a history of or are currently using any form of tobacco or cannabis (including vape)?

☐ Yes ☐ No ☐ Current Use ☐ Former Use

How long have/were you using that product for? _____

How much tobacco or cannabis do you consume? _____

What form of tobacco or cannabis do you use? (ie: cigarettes, vape, etc.) _____

Emergency Contact

Name: _____

Relationship: _____ Phone Number: _____

Dental History

Date of last dental checkup? _____

Would you like to have records forwarded to us from a previous dental office? ☐ Yes ☐ No

If so, which office? _____

Are you currently experiencing any pain/discomfort or sensitivity? ☐ Yes ☐ No

Please explain: _____

What is your main concern regarding your teeth or mouth? _____

Do you have any goals concerning your teeth and mouth? (Ex: Improve Hygiene, Esthetics, etc)

_____

Is there anything about your smile that you would like to change?

_____

Are there any aspects of dental treatment that make you nervous? Please specify. This allows us to make your experience as comfortable as possible for you.

_____

Would you like information on the various methods of sedation available in our office?

☐ Yes ☐ No

Disclaimer & Consent Form

I have completed these forms to the best of my knowledge and understand that should there be any change in my health, it is my responsibility to inform River North Dental Centre at my next appointment.
I do hereby consent to an oral examination and diagnostic aids such as x-rays and photographs. I give my permission for these images to be used for the purpose of education. All images will be stored in a secured location and only authorized staff will have access to them.
I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed prior to services being rendered.
I authorize the release of information concerning my oral health to other dentists or specialists for referral purposes and/or transfer of care.
I understand that River North Dental will bill directly to my insurance company, when able to, and that any remaining balance is my responsibility to pay for in full. Should arrangements need to be made, I understand that it is my responsibility to communicate that with River North Dental Centre staff.
I understand that should an estimate of treatment be provided that the costs listed are subject to change.

By signing, I state that I have read the above conditions and agree with their content.

_____ _____

Signature of Patient Date