PERSONAL HISTORY (Please Print)

Mr. Mrs.
Patient's Name Ms. Dr. _____
Last First Middle

Please circle the name you prefer to be called

Home Address _____ Date of Birth _____
City _____ Province _____ Postal Code _____
Home Phone No. _____ Work Phone No. _____
Email Address _____ Cell No. _____
Can best be contacted at Home ☐ Work ☐ please check one
Your Employer _____ Occupation _____
Business Address _____
Your Physician _____ Physician Phone No. _____
Previous Dentist _____
Last visit to Dental Office for a cleaning? _____

Whom may we thank for referring you? _____
Nearest Relative _____ Relation _____ Phone No. _____

FINANCIAL RESPONSIBILITY

Payment is accepted at the time service is rendered. We are happy to provide you with an estimate. You may pay your account by Cash, Visa, Mastercard, Cheque, American Express. The following Dental Insurance information allows us to assist you in better utilizing your insurance benefits.

Are you covered by dental insurance? Yes No
Do you have a second insurance from a spouse or other? Yes No

PLEASE ALLOW ONE OF US FROM THE OFFICE TO FILL OUT THE FOLLOWING WITH YOU.

Insurance Company _____
_____
Name of Subscriber _____
ID Number _____
Plan Number _____
Employer _____
Birth Date _____
Breakdown of Coverage _____

2nd Insurance Company _____
_____
Name of Subscriber _____
ID Number _____
Plan Number _____
Employer _____
Birth Date _____
Breakdown of Coverage _____

MEDICAL HISTORY

1. When was your last general check up with a physician? _____
2. Are you in good health now? _____
3. Are you taking any Non Prescription medications? _____
4. Are you now taking any medications, tablets, pills? _____
5. Are you presently being treated by a physician? _____
6. Have you ever been hospitalized? _____
7. Have you ever had an unusual reaction to any drugs? _____
8. Do you suffer from any allergies? _____
9. Have you ever had a serious illness? _____
10. Have you ever been told not to give blood? _____
11. Have you ever had Rheumatic Fever or a heart murmur? _____
12. Do you have any problems with prolonged bleeding? _____
13. Women: Are you pregnant? _____ Due date _____

Do you have or have you ever had any of the following? (Please circle)

HEART TROUBLE OR STROKE
HEPATITIS: A B C E
SWOLLEN FEET/ANKLES
TUBERCULOSIS, EMPHYSEMA
RHEUMATIC FEVER
BLOOD DISORDER
CHEST PAINS, SHORTNESS OF BREATH
DIABETES
ARTHRITIS
HIV/AIDS
FAINTING SPELLS
PACEMAKER
MULTIPLE SCLEROSIS
GLAUCOMA
SMOKER

NERVOUSNESS
CANCER
THYROID PROBLEM
ANY RESPIRATORY PROBLEMS
EPILEPSY OR SEIZURES
KIDNEY DISEASE
VENEREAL DISEASE (STD)
ASTHMA OR ALLERGIES
ABNORMAL HEART SOUNDS
HIGH OR LOW BLOOD PRESSURE
ARTIFICIAL JOINTS
JAUNDICE
LIVER DISEASE
OTHERS: _____

NOTES: _____

(CONSENT FOR TREATMENT)

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.
PAYMENT IS EXPECTED AS SERVICES ARE RENDERED, UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

Patient's (Parent's) Signature _____ Date _____