Oakville
Family & Cosmetic Dentistry

ALL INFORMATION IS STRICTLY CONFIDENTIAL & WILL REMAIN WITH THIS OFFICE

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Date: _____

First Name _____ Middle Name _____ Last Name _____

Street _____ Unit # _____

City _____ Province _____ Postal Code _____

Home Phone Number _____ Business Phone Number _____ Other Phone Number _____

Date of Birth (DAY/MONTH/YEAR) _____ Marital Status _____

Occupation _____ Employer _____

Email Address _____ Person Responsible for Account _____

DENTAL INSURANCE: ☐ Yes ☐ No Name of Insured or Employee: _____

Insurance Company _____ Insured's Date of Birth _____

Policy Plan Number _____ Certificate/Subscriber Number _____ Employee ID Number _____

ADDITIONAL INSURANCE: ☐ Yes ☐ No Name of Insured or Employee: _____

Insurance Company _____ Insured's Date of Birth _____

Policy Plan Number _____ Certificate/Subscriber Number _____ Employee ID Number _____

Family Physician Name _____ Physician Phone Number _____ Date of Last Visit _____

IN CASE OF EMERGENCY NOTIFY:

Name _____ Phone Number _____ Relationship _____

APPOINTMENT OFFICE POLICY

Payment for services rendered are expected at the end of each dental visit. In order to treat you effectively, we will reserve an appointment time solely for you. We require your co-operation in keeping these appointments. If you cannot keep your appointed time, we require **2 FULL BUSINESS DAYS' NOTICE**. Otherwise, a fee will be assessed. _____ (Initials)

REFERRAL INFORMATION: Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Yellow Pages ☐ Another Patient ☐ Online Search ☐ Sign

Name of Person or Doctor referring you to our practice: _____

CONFIDENTIAL MEDICAL HISTORY: Are you currently taking any pills, drugs or medication? ☐ Yes ☐ No

Name of Medication and Dosage:

_____

_____

_____

Do you have any **allergies** to any drugs or medicines? (i.e. penicillin, Aspirin, etc.) ☐ Yes ☐ No

IF YES, PLEASE SPECIFY: _____

Have you ever been hospitalized? ☐ Yes ☐ No

IF YES, PLEASE SPECIFY: _____

Do you have a heart murmur or mitral valve prolapse? ☐ Yes ☐ No

Have you ever had rheumatic fever? ☐ Yes ☐ No

Do you have any (replacement)/artificial joints or limbs? ☐ Yes ☐ No

Do you take **pre-medication** for dental appointments? ☐ Yes ☐ No

Have you ever had abnormal bleeding? ☐ Yes ☐ No

If you are a woman, are you currently pregnant? ☐ Yes ☐ No

Do you have or have you ever had any of the following? Please check all that apply:

☐ AIDS	☐ Epilepsy	☐ Kidney Disease	☐ Stroke
☐ Allergies _____	☐ Fainting	☐ Liver Disease	☐ Swollen Ankles
☐ Anemia	☐ Glaucoma	☐ Mental Disorders	☐ Tuberculosis
☐ Arthritis	☐ Growths	☐ Nervous Disorders	☐ Tumors
☐ Artificial Joints	☐ Hay Fever	☐ Pacemaker	☐ Ulcers
☐ Asthma	☐ Head Injuries	☐ Radiation Treatment	☐ Venereal Disease
☐ Blood Disease	☐ Hepatitis	☐ Respiratory Problems	☐ Other:
☐ Cancer	☐ HIV	☐ Rheumatism	_____
☐ Diabetes	☐ High Blood Pressure	☐ Sinus Problems	_____
☐ Dizziness	☐ Jaundice	☐ Stomach Problems	_____

CONFIDENTIAL DENTAL HISTORY:

How often do you see a dentist? ☐ 6 Months ☐ Yearly ☐ Other: _____

How long ago was your last dental visit? _____

Do you have a specific dental problem at the moment? Please specify: _____

Have you ever had a reaction to dental anaesthetic (freezing)? ☐ Yes ☐ No

Are any of your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Other: _____

Do your gums bleed when: ☐ Brushing ☐ Flossing

Are you aware of any loose teeth? ☐ Yes ☐ No

Do you currently experience:

☐ Earache	☐ Spaced or Crooked Teeth	☐ Popping/Clicking in Jaw Joint	☐ Neck Pain
☐ Bad Breath	☐ Discoloured Dark Teeth	☐ Unsatisfactory Dentures	☐ Gagging
☐ Nosebleeds	☐ Headache	☐ Sore Gums	☐ Stained Teeth

On a scale of 1 to 10 (1 being poor, 10 being excellent), how would you rate your smile? _____

PATIENT CERTIFICATION

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. The practice depend upon reimbursement for services at the time services are rendered. I will assume responsibility of fees associated with these procedures.

Signature (Patient/Parent or Guardian): _____ **Date:** _____