WELCOME TO OUR DENTAL OFFICE

Downtown Georgetown Dental

☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. Last Name: _____ First Name: _____ Initial: _____

Preferred Name: _____ Date of Birth: D D / M M / Y Y Y Y ☐Male ☐Female ☐Adult ☐Child

Address: _____ Apt/Unit#: _____ City: _____ Province: _____ Postal Code: _____

Home ☎: (____) ____ - _____ Work ☎: (____) ____ - _____ x _____ Cell ☎: (____) ____ - _____ Other ☎: (____) ____ - _____

Best way to contact: ☐Home ☐Work ☐Cell ☐Email Best time to contact: ☐Morning ☐Afternoon ☐Evening

Email: _____ Marital Status: ☐Single ☐Married/Common Law ☐Other

In case of emergency notify: _____ Relation: _____ ☎ (____) ____ - _____

Family Physician: _____ ☎ (____) ____ - _____

Employer / School: _____ Occupation: _____

Person responsible for this account: ☐Self ☐Spouse ☐Parent ☐Legal Guardian ☐Other: _____

Last Name: _____ First Name: _____ Initial: _____ Relation: _____

Address: _____ Apt/Unit#: _____ City: _____ Province: _____ Postal Code: _____

Home ☎: (____) ____ - _____ Work ☎: (____) ____ - _____ x _____ Cell ☎: (____) ____ - _____ Other ☎: (____) ____ - _____

How did you hear about us? (Check all that apply)

☐Flyer ☐Newspaper ☐Email Newsletter ☐Yellow Pages / Phone Book ☐Direct Mail ☐Walked By

☐Friend / Word of Mouth - Who may we thank for referring you to us? _____

☐Internet - Please Specify: _____ ☐Other - Please Specify: _____

PRIMARY INSURANCE

Policy Holder Name: _____

Date of Birth: D D / M M / Y Y Y Y

Relation: ☐Self ☐Spouse ☐ Parent ☐Other: _____

Insurance Co.: _____

Policy / Plan #: _____ ID / Cert. #: _____ Div. / Sec. #: _____

SECONDARY INSURANCE

Policy Holder Name: _____

Date of Birth: D D / M M / Y Y Y Y

Relation: ☐Self ☐Spouse ☐ Parent ☐Other: _____

Insurance Co.: _____

Policy / Plan #: _____ ID / Cert. #: _____ Div. / Sec. #: _____

MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment.	YES	NO
1. Have you ever had a serious illness requiring hospitalization or extensive medical care?	☐	☐
If yes, please specify: _____		
2. Are you presently under the care of a physician? If yes, please explain: _____	☐	☐
3. Do you use any prescription or non-prescription drugs regularly?	☐	☐
If yes, please specify: _____		
4. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex?	☐	☐
5. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea?	☐	☐
If yes, please specify: _____		
6. Have you been hospitalized in the last 5 years? If yes, please specify: _____	☐	☐
7. Have you ever experienced any unusual reaction to any of the following? (Please circle)	☐	☐
local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine?		
If yes, please explain: _____		
8. Have you been warned against taking any drug or medication?	☐	☐
9. Do you bruise easily or bleed abnormally?	☐	☐
10. Do you require pre-medication for dental treatment?	☐	☐
11. Have you ever had any organ transplants or medical implants?	☐	☐
12. Do your ankles swell?	☐	☐
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐

	YES	NO
14. Have you had any injury, surgery, or x-ray therapy to your face or jaws?	☐	☐
15. Do you have any disease, condition, or problem that you think the doctor should know about?	☐	☐
16. WOMEN ONLY - Are you pregnant or suspect you might be? If yes, what month are you in? _____	☐	☐
Are you taking birth control pills?	☐	☐
Are you nursing?	☐	☐
17. Do you have a drug addiction or use any recreational drugs?	☐	☐
****If yes, please refrain from usage one (1) week prior to sedation. Usage before anesthesia is extremely harmful.**		
18. Do you drink alcohol?	☐	☐
If yes, please indicate how much alcohol you drink: _____ /day _____ /week _____ /month		

Please check any of the following that may apply to you:

☐AIDS / HIV positive	☐Cancer / Chemotherapy	☐Heart lesions, congenital	☐Liver disease	☐Sinus trouble
☐Allergies, seasonal	☐Diabetes	☐Heart murmur	☐Low blood pressure	☐Snoring / Sleep apnea
☐Anemia	☐Dizziness	☐Heart surgery	☐Mitral valve prolapse	☐Stomach problems
☐Arthritis / Rheumatism	☐Drug addiction	☐Hepatitis A, B, C	☐Nervousness / Depression	☐Stroke
☐Artificial heart valve	☐Emphysema	☐High blood pressure	☐Pacemaker	☐Thyroid disease
☐Artificial joints	☐Excessive bleeding	☐Herpes / Cold sore	☐Respiratory problems	☐Tuberculosis
☐Asthma	☐Fainting	☐Jaundice	☐Rheumatic fever	☐Ulcers
☐Blood disease	☐Glaucoma	☐Jaw joint pain	☐Scarlet fever	☐Venereal diseases
☐Bruise easily	☐Heart conditions	☐Kidney disease	☐Seizures	☐Other: _____

DENTAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment.

	YES	NO
1. Have you ever smoked? If yes, how many years? _____	☐	☐
2. Do you currently smoke? Number per day: _____	☐	☐
3. Previous problems with dental treatments? If yes, please specify: _____	☐	☐
4. Would you be interested in different sedation options to make your visits more relaxing?	☐	☐

5. Why did you leave your previous dentist? _____
6. What, if anything, in the past has kept you from having dental treatment? _____
7. What is the most important thing to you about your future smile and dental health? _____
8. What is the most important thing to you about your visit today? _____
9. Please share the following dates. Last dental cleaning: _____ Last oral cancer screening: _____ Last X-Rays: _____

Please check any of the following that may apply to you:

☐Sensitivity (hot, cold, sweet)	☐Tooth pain or discomfort while chewing	☐Headaches, earaches, neck pain
☐Jaw joint pain (clicking/cracking)	☐Teeth or fillings breaking	☐Grinding or clenching teeth
☐Bleeding, swollen or irritated gums	☐Loose, tipped or shifting teeth	☐Bad breath or bad taste in your mouth
☐Loose/Poor fitting dentures	☐Wears dentures	☐Previous orthodontics or gum surgery

If I could improve my oral health, I would...

☐Make my teeth brighter	☐Make my teeth straighter
☐Close spaces	☐Repair chipped teeth
☐Replace missing teeth	☐Replace old crowns that don't match
☐Have a smile makeover	☐Replace black metal fillings with natural, tooth coloured fillings

On a scale of 1 (low) to 10 (high)...

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10
How would you rate the look & feel of your smile?
1 2 3 4 5 6 7 8 9 10

Office policy: Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we will require **48 business hours** notice. Otherwise, it may be necessary to charge for time lost.

Patient Release: I, the undersigned, certify that I have provided an accurate and complete personal, medical, and dental history and have not knowingly omitted any information. I authorize the dentist and his/her auxiliary staff to perform diagnostic procedures and treatment as may be necessary for proper dental care. If required, I consent to my physician being contacted regarding any specific medical question. I understand that I am financially responsible to the dentist for the dental services provided for myself and my dependents.

I agree that Downtown Georgetown Dental has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used, and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

_____ _____

(Signature) ☐Patient ☐Parent ☐Guardian Reviewing Dentist

Please Print Name: _____ Date: _____

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