Promenade Dental Office

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

TODAY'S DATE: / / (dd mm yy)

NAME: (LAST FIRST INITIAL MR MRS MS DR)

I PREFER TO BE CALLED: ☐ MALE ☐ FEMALE

BIRTH DATE: / / (dd mm yy) AGE:

HOME ADDRESS:

(CITY PROVINCE POSTAL CODE)

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

HOME #: FAX #:

WORK #: EXT.: CELL#:

E-MAIL ADDRESS:

EMPLOYER:

EMPLOYER'S ADDRESS:

HOW LONG THERE? OCCUPATION:

WHERE & WHEN ARE THE BEST TIMES TO REACH YOU?

WHOM MAY WE THANK FOR REFERRING YOU?

OTHER FAMILY MEMBERS SEEN BY US:

PREVIOUS / PRESENT DENTIST: (PLEASE CIRCLE ONE)

LAST VISIT DATE: / / (dd mm yy)

2 Spouse Information

HIS / HER NAME:

EMPLOYER:

WORK #: EXT.: CELL#:

BIRTH DATE: / / (dd mm yy) SIN #:

In the event of an emergency, is there someone who lives near you that we should contact?

HIS / HER NAME: RELATION:

WORK #: HOME #:

CELL #:

Person Responsible For Account

NAME: RELATION:

BILLING ADDRESS: (STREET/APT. # CITY PROVINCE POSTAL CODE)

BUS #: EXT.: HM #: CELL #: SIN #:

3 Dental Insurance

Primary Dental Insurance

INSURANCE COMPANY NAME:

POLICY / GROUP #: DIVISION #:

CERTIFICATE / ID #:

INSURED'S NAME: RELATION:

INSURED'S BIRTH DATE: / / (dd mm yy)

INSURED'S SIN #:

INSURED'S EMPLOYER:

Secondary Dental Insurance

INSURANCE COMPANY NAME:

POLICY / GROUP #: DIVISION #:

CERTIFICATE / ID #:

INSURED'S NAME: RELATION:

INSURED'S BIRTH DATE: / / (dd mm yy)

INSURED'S SIN #:

INSURED'S EMPLOYER:

4 Medical History

DO YOU HAVE A PERSONAL PHYSICIAN? ☐ YES ☐ NO

PHYSICIAN'S NAME:

PHONE #: DATE OF LAST VISIT: / / (dd mm yy)

YOUR CURRENT PHYSICAL HEALTH IS: ☐ GOOD ☐ FAIR ☐ POOR

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

PLEASE EXPLAIN:

ARE YOU CURRENTLY TAKING ANY MEDICATION? ☐ YES ☐ NO

PLEASE LIST EACH ONE:

DO YOU SMOKE OR USE TOBACCO IN ANY OTHER FORM? ☐ YES ☐ NO

For Women:

ARE YOU TAKING BIRTH CONTROL PILLS? ☐ YES ☐ NO

ARE YOU PREGNANT? ☐ YES ☐ NO WEEK #:

ARE YOU NURSING? ☐ YES ☐ NO

Have you ever had any of the following medical problems?

please circle Y or N and underline those that apply to you:

Y N	ANEMIA / RADIATION TREATMENT	Y N	HEART SURGERY / PACEMAKER		
Y N	ARTIFICIAL BONES / JOINTS	Y N	HEMOPHILIA / BLEEDING		
Y N	ARTIFICIAL VALVES	Y N	HEPATITIS / SARS		
Y N	ASTHMA / ARTHRITIS	Y N	HIGH / LOW BLOOD PRESSURE		
Y N	BLOOD TRANSFUSION	Y N	HIV+ / AIDS		
Y N	CANCER / CHEMOTHERAPY	Y N	HOSPITALIZED FOR ANY REASON		
Y N	CONGENITAL HEART DEFECT	Y N	KIDNEY PROBLEMS		
Y N	DIABETES / TUBERCULOSIS (TB)	Y N	MITRAL VALVE PROLAPSE		
Y N	DIFFICULTY BREATHING	Y N	PSYCHIATRIC PROBLEMS		
Y N	DRUG / ALCOHOL ABUSE	Y N	RHEUMATIC / SCARLET FEVER		
Y N	EMPHYSEMA / GLAUCOMA	Y N	SEVERE / FREQUENT HEADACHE		
Y N	EPILEPSY / SEIZURES / FAINTING	Y N	SHINGLES		
Y N	FEVER BLISTERS / HERPES	Y N	SINUS PROBLEMS		
Y N	HEART ATTACK / STROKE	Y N	ULCERS / COLITIS		
Y N	HEART MURMUR	Y N	VENEREAL DISEASE		

PLEASE LIST ANY OTHER MEDICAL CONDITIONS THAT YOU HAVE EVER HAD:

Are you allergic to any of the following?

please circle Y or N and underline those that apply to you:

Y N	ASPIRIN	Y N	ERYTHROMYCIN	Y N	TETRACYCLINE
Y N	CODEINE	Y N	LATEX	Y N	SULPHA
Y N	PENICILLIN	Y N	JEWELLERY/METALS	Y N	DENTAL ANAESTHETICS

PLEASE LIST ANY OTHER DRUGS / MATERIALS THAT YOU ARE ALLERGIC TO:

5 Dental History

WHY HAVE YOU COME TO THE DENTIST TODAY?

DO YOU REQUIRE ANTIBIOTICS BEFORE DENTAL TREATMENT? ☐ YES ☐ NO

ARE YOU CURRENTLY IN PAIN? ☐ YES ☐ NO

HAVE YOU EVER HAD A SERIOUS PROBLEM ASSOCIATED WITH ANY PREVIOUS DENTAL WORK? ☐ YES ☐ NO

DO YOU NOW OR HAVE YOU EVER EXPERIENCED PAIN / DISCOMFORT IN YOUR JAW JOINT? (TMJ / TMD)? ☐ YES ☐ NO

YOUR CURRENT DENTAL HEALTH IS ☐ GOOD ☐ FAIR ☐ POOR

DO YOU LIKE YOUR SMILE? ☐ YES ☐ NO

DO YOUR GUMS EVER BLEED? ☐ YES ☐ NO

HOW MANY TIMES A WEEK DO YOU FLOSS?

HOW MANY TIMES A DAY DO YOU BRUSH?

TYPE OF BRISTLES? ☐ HARD ☐ MEDIUM ☐ SOFT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

SIGNATURE DATE (dd/mm/yy)

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help. Our office is committed to meeting or exceeding the standards of infection control mandated by the Canadian Dental Association.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with patient named herein. Initials: Date: / / (dd mm yy)

DOCTOR'S COMMENTS:

1. DATE: / / (dd mm yy) COMMENTS: SIGNATURE:

2. DATE: / / (dd mm yy) COMMENTS: SIGNATURE:

3. DATE: / / (dd mm yy) COMMENTS: SIGNATURE: