SCARBOROUGH DENTALCARE

1571 Sandhurst Circle
Scarborough, ON M1V 1V2
(416) 321-9500

PATIENT INFORMATION

TITLE: MR / MISS

PATIENT LAST NAME

FIRST NAME

DATE OF BIRTH (DAY/MONTH/YEAR)

GENDER: M / F

ADDRESS

CITY

POSTAL CODE

PHONE (HOME) ☐ preferred

PHONE (MOBILE) ☐ preferred

PHONE (OTHER) ☐ preferred

EMAIL

You will receive automated reminders* for your upcoming appointments.
Please select your preferred delivery method(s).
You may select more than one.

☐ TEXT (SMS)*
☐ EMAIL*
☐ PHONE CALL
☐ POSTCARD (mailed 3 weeks before apt.)

OCCUPATION, IF WORKING

EMPLOYER

PHONE (WORK)

FATHER'S FULL NAME | EMPLOYER | OCCUPATION | PHONE NUMBER

MOTHER'S FULL NAME | EMPLOYER | OCCUPATION | PHONE NUMBER

EMERGENCY CONTACT | RELATIONSHIP | PHONE NUMBER

FAMILY PHYSICIAN | PHONE NUMBER

REGULAR PHARMACY | PHONE NUMBER | FAX NUMBER

DO YOU HAVE DENTAL INSURANCE? Y / N

NAME OF INSURANCE COMPANY

DATE OF LAST DENTAL APT.

WHO IS RESPONSIBLE FOR YOUR ACCOUNT PAYMENT?

HOW DID YOU HEAR ABOUT US?

Authorization & Consent for Treatment

I certify that the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information.
I consent to the dental procedures being performed and assume responsibility for fees associated with those procedures.

PATIENT/PARENT/GUARDIAN | SIGNATURE | DATE

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MEDICAL QUESTIONNAIRE

Do you have:

Any congenital heart disease?	Y	N
Have you been advised to take prophylactic antibiotics before your dental appointment?	Y	N

Do you have:

Any heart condition?	Y	N
High blood pressure?	Y	N
Diabetes?	Y	N
Bleeding Tendency?	Y	N

Any allergies/unfavourable reactions to:

Latex	Y	N
Local anaesthetics (freezing)	Y	N
General anaesthetics	Y	N
Penicillin	Y	N
Erythromycin	Y	N
Other antibiotics _____	Y	N
Aspirin	Y	N
Codeine	Y	N

Do you have:

Any serious illness? _____	Y	N
Any serious operation? _____	Y	N
History of Cancer?	Y	N
Are you undergoing chemotherapy?	Y	N
Lung or breathing problems?	Y	N
Liver or kidney problems?	Y	N
Asthma?	Y	N
Epilepsy?	Y	N
Thyroid disease?	Y	N

Have you ever tested Positive for:

Hepatitis B?	Y	N
AIDS / HIV?	Y	N
Tuberculosis (TB)?	Y	N

Do you consume the following?

Do you use alcohol?	Y	N
Do you smoke cigarettes?	Y	N
Do you vape?	Y	N
Do you use cannabis?	Y	N
Girls: Are you pregnant?	Y	N

Due Date? _____

Medication Name & Dosage

Please list all medication(s) you are currently taking:

_____

_____

_____

_____

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PATIENT/PARENT/GUARDIAN	SIGNATURE	DATE

_____ Dentist Signature

_____ Date