SCARBOROUGH DENTALCARE

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

PATIENT INFORMATION

TITLE: MR / MRS / MISS / MS DR

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

EMPLOYER

PHONE (WORK)

SPOUSE

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.

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:

Prosthetic heart valve?	Y	N
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
A Pacemaker?	Y	N
History of stroke?	Y	N
High blood pressure?	Y	N
Diabetes?	Y	N
Bleeding Tendency?	Y	N
Osteoporosis?	Y	N
If so, are you taking medication?	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
High Cholesterol?	Y	N
Epilepsy?	Y	N
Thyroid disease?	Y	N
Chronic Obstructive Pulmonary 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
Women: Are you pregnant?	Y	N

Due Date? _____

Medications

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

_____

_____

_____

_____

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PATIENT/PARENT/GUARDIAN	SIGNATURE	DATE

_____ Dentist Signature

_____ Date