Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

			Patient #
D. C. L. C.			SS#/SIN
Patient Informa	ation (Confii	DENTIAL)	Date
			Home Phone
Address		City	Home Phone State/ Zip/ Prov P. C
Check Appropriate Box: Minor	☐ Single ☐ Married ☐	☐ Divorced ☐ Widowed	□ Separated
If Student, Name of School/College _		City	State/ Full Part Prov Time Time
Patient or Parent/Guardian's Employ			Work Phone
Business Address			State/ /in/
			Work Phone
Whom may we thank for referring y			
			Phone
Responsible Pa	rty		Relationship
Name of Person Responsible for this	s Account		to Patient
Address			Home Phone
Email			Cell Phone
Driver's License#	Birthdate	Financial Instit	tution
Employer		Work Phone	SS#/SIN
Is this person currently a patient in	our office?] No	
For your convenience, we offer the fo	ollowing methods of paymen	t. Please check the option you pre	fer. Payment in full at each appointment.
☐ Cash ☐ Personal Check			I wish to discuss the office's payment policy.
Incurance Infor			
Insurance Infor			Relationship to Patient
Name of Insured			
			Date Employed
Name of Employer		Union or Local#	Work Phone
Address of Employer		City	State/ Zip/ Prov. P.C.
Insurance Company Ins. Co. Address		Group#	Policy/ID#
Ins. Co. Address		City	State/ Zip/ Prov. P. C.
How much is your deductible?	How mucl	n have you used?	Max. annual benefit
DO YOU HAVE ANY ADDITION	NAL INSURANCE?	Yes □ No IF YES, C	OMPLETE THE FOLLOWING:
Name of Insured			Relationship to Patient
Birthdate			Date Employed
Name of Employer			Work Phone
Address of Employer			State/ Zip/
Insurance Company			
Ins. Co. Address			State/ Zip/ Prov. P. C
How much is your deductible?			
110W much is your deductible!		nuve you useu: Over Please	www. annual benefit

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Physician	Office Phone	e					Date of La	ast Exam			
		Yes	No	10 1						Yes	N
1. Are you under medical treatment now?			Ш	10. Are yo	u wea	aring co	ontact lense.	s?			L
2. Have you ever been hospitalized for any								ry reactions to the foll			-
surgical operation or serious illness within the las	st 5 years?[Local A	Anesth	netics (e.g. Novoca	in)		H	_
If yes, please explain								tics		H	-
33 71 1											-
Are you taking any medication(s)										H	-
including non-prescription medicine?	[H	-
If yes, what medication(s) are you taking?										Н	L
3 / 50,											-
. Have you ever taken Fen-Phen/Redux?								ry, etc.)		Н	_
. Have you ever taken Fosamax, Boniva, Actonel or a											L
medications containing bisphosphonates?	ary curicer		П	Other (
Have you taken Viagra, Revati, Cialis or Levitra								throat clearing not			-
in the last 24 hours?							wn illness (la	sting more than 3 w	veeks)?		L
Do you use tobacco?		Ħ.	Ħ.	13. Wome							
Do you use controlled substance?		T .	Ħ	a) Are	you p	regnan	it or think y	ou may be pregne	ant?	Ш	L
Do you use controlled substances?				b) Are	you n	ursing	?				
. Do you have or have you had any of the following	Ŗ!							eptives?			
Yes No)					No				Yes	N
High Blood Pressure	Heart Disease	e					Chest Pain	S			Ī
Heart Attack	Cardiac Pacer							ded			Ī
Rheumatic Fever	Heart Murmu										Ī
Swollen Ankles	Angina							/ Allergies			Ī
Fainting / Seizures	Frequently Ti						Tuberculos	is		n	Ì
Asthma	Anemia							Therapy			Ī
Low Blood Pressure	Emphysema .					$\overline{\Box}$		·····			ř
Epilepsy / Convulsions	Cancer					Ħ-		ight Loss			ř
Leukemia	Arthritis			The state of the s		Ħ.	Liver Dise	ase		H	ř
Diabetes					ī i	Ħ.		ble			F
	Joint Replacer					H		y Problems			F
Kidney Diseases	Hepatitis / Jai	unaice									
ALL IN ON HILV Instaction	Carriallas Treas				Ħ	H	Mitual Val-	y Problems		H	F
Thyroid Problem	Sexually Tran Stomach Trou	ısmitte	ed Disea	se			Mitral Valv	ve Prolapse			
Patient Dental Histo	Stomach Trou	ismitte ibles /	ed Disea Ulcers	se			Mitral Val	ve Prolapse			
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