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Oakville DENTISTRY

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ABOUT YOU

Today's Date: ____ / ____ / ____ (dd / mm / yyyy)

Name: _____ (Last / First / Middle)

I prefer to be called: _____ Gender ☐ M ☐ F

DOB: ____ / ____ / ____ (dd / mm / yyyy) SIN: _____

Home Address: _____

_____ Postal Code: _____

Hm # : ( ) _____ Cell # : ( ) _____

Wk # : ( ) _____ Email : _____

Employer: _____

Occupation: _____

How did you hear about us: _____

Other family members seen by us: _____

_____

Spouse / Parent Name: _____

Emergency Contact: _____

Cell # : ( ) _____ Hm # : ( ) _____

DENTAL HISTORY

Reason for today's visit: _____

Previous Dentist: _____

Ph: ( ) _____

Date of last teeth cleaning: _____

Date of last dental x-rays: _____

Are you having any discomfort at this time? ☐ Y ☐ N

Please specify: _____

Are you aware of any lump or swelling in your mouth? ☐ Y ☐ N

Are you satisfied with the appearance of your tooth? ☐ Y ☐ N

Are you anxious to keep your natural teeth? ☐ Y ☐ N

Are you tense during dental visit? ☐ Y ☐ N

Do you currently experience: (please circle)

Bad breath	Broken filling	Sore gums
Bleeding gums	Bar ache	Headache
Sensitive teeth	Missing teeth	Gagging
Loose teeth	Grinding teeth	Neck Pain
Unexplained nosebleed	Unsatisfactory dentures	Spaced or crooked teeth
Clicking or popping jaw		

DENTAL INSURANCE (Let Us Fill This Section)

Insurance Co. Name: _____

Member's Name: _____ Relation: _____

Insured's Employer: _____ DOB: _____

Group # / Policy #: _____ ID #: _____

DENTAL HISTORY *continued.*

Are you interested in whiter teeth? ☐ Y ☐ N

How often do you brush? _____

How often do you floss?. _____

WOMEN ONLY:

Are you pregnant or think you may be pregnant? ☐ Y ☐ N

Due Date: _____

Are you nursing? ☐ Y ☐ N

Are you taking oral contraceptives? ☐ Y ☐ N

MEDICAL HISTORY

Physician's Name: _____

Phone#: ( ) _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Y ☐ N

Please specify: _____

Are you taking any prescription / over the-counter drugs? ☐ Y ☐ N

Please list each one: _____

_____

Have you taken any prolonged medication in the past (prescription or non-prescription) ? ☐ Y ☐ N

Do you smoke / use tobacco in any other form? ☐ Y ☐ N

Please specify: _____

Have you taken cortisone or steroids? ☐ Y ☐ N

Are you allergic to any of the following? (please circle)

Local Anaesthesia	Any Metals
Codeine	Barbiturates
Penicillin or other Antibiotics	Latex Rubber
Aspirin	Iodine
Sulfa Drugs	Other _____

Please Turn Over

MEDICAL HISTORY *Continued.*

Have you ever had any of the following conditions or medical problems? (please circle)

Heart (Surgery, Disease, Attack)
Chest Pain
Heart Murmur
High/Low Blood Pressure
Rheumatic Fever
Scarlet Fever
Arthritis / Rheumatism
Stroke
Artificial Joints (Hip / Knees)
Kidney Problems

Ulcers
Diabetes
Thyroid Problems
Glaucoma
Emphysema
Difficulty Breathing
Neurological Disorders
Hospitalized / Surgery Performed
Psychiatric / Psychological Care
Tuberculosis

Asthma
Hay Fever
Sinus Problems
Radiation / Chemotherapy
Cancer
Hepatitis A (infectious)
Hepatitis B (serum)
Drug / Alcohol Abuse
Venereal Disease
A.I.D.S. / H.I.V. Positive

Hemophilia
Sickle Cell Disease
Bruise Easily
Liver Disease
Abnormal Bleeding
Fainting / Dizzy Spells
Nervous / Anxious
Epilepsy / Seizures
Swollen Ankles
Other

PATIENT'S CONSENT - PLEASE READ CAREFULLY BEFORE SIGNING

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedure agreed to be necessary or advisable, including the use of Anesthesia as indicated and I will assume responsibility for fees associated with these procedures, risk, benefits cost, payment plan was discussed with me in details. I completely understand & agree to get the treatment performed.

I also certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I also consent to the collection, use or disclosure of personal information as is required for my dental care. I hereby authorize the release of information contained in claims administrator.

COMPREHENSIVE EXAM RELEASE
I authorize Oakville Dentistry to take the necessary radiographs and perform any other procedures that the dental professionals deem necessary to comprise a comprehensive treatment plan.

PAYMENT AGREEMENT
I understand and agree that health, dental and accident insurance policies are an agreement between an insurance carrier and myself. I understand that Oakville Dentistry will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I will also be responsible for the payments to the treatment done, after expiration / termination of my or my family's dental Insurance coverage. I will inform Oakville Dentistry immediately upon knowing any changes to my insurance policy. If the cheque from the insurance comes to me and I have not paid for the treatment, I will immediately hand over the cheque to Oakville Dentistry. I understand and agree that this office, as a courtesy to me, will not impose any interest charge to any balance. I may incur for a period of thirty days after the charges are incurred, to afford my insurance carrier, if any, that amount of time to make payment. It is understood that any balances outstanding for more than thirty days will be charged interest at the rate of 1.5 percent per month and I agree to pay said charges. In the event my account balance is referred to an agency or attorneys for collection purposes. I agree to pay reasonable attorney's fees and any expenses or costs. In the event that the patient is a minor, I am the parent and/or guardian or said patient and agree that I am responsible for all services rendered to the patient herein. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

AUTHORIZATION OF PAYMENT OF BENEFITS
I hereby authorize payment directly to Oakville Dentistry . I agree that a photocopy of this authorization is as valid as the original.

Signature (Patient/Parent/Guardian) _____ Date: _____

MEDICAL UPDATES

Date	Changes	Signature