NEW PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you.

PERSONAL INFORMATION

First Name _____ Last Name _____
Date of Birth _____Gender _____ Marital Status _____
Address_____ City _____ Postal Code _____
Phone (Home) _____(Cell) _____(Work) _____
Email _____
Emergency Contact _____ Relationship _____
Contact _____
How did you hear about us? _____
(If someone referred you here, please enter their name so we can thank them.)

INSURANCE INFORMATION

PRIMARY INSURANCE

Do you have dental insurance? YES NO

Name of Insured_____

Date of Birth_____

Insurance Company_____

Group #_____

ID#_____

SECONDARY INSURANCE

Relationship to Subscriber
☐ SELF ☐ SPOUSE ☐ CHILD

Subscriber's Name_____

Date of Birth_____

Insurance Company_____

Group #_____

ID#_____

DENTAL INFORMATION

Reason for Today's Visit: _____
Former Dentist: _____
Date of Last Visit: _____Date of Last X-Rays: _____
How often do you brush: _____ Floss: _____

HEALTH INFORMATION

Physician's Name _____Date of Last Exam _____
Health Card/Driver's Licence (Needed for Prescriptions) #_____
Are you under the care of a Physician for any Medical problems? Please List.
_____
Have you ever had a surgery or illness for which you have been hospitalized?
_____
Have you had any recent hospital visits within the last two years? If yes, please provide details.
_____
Do you have any allergies (Latex, Codeine, Penicillin etc.)? Please List.
_____
Do you smoke? _____No of Cigarettes/day _____How long have you been smoking? _____
Is there any chance you are Pregnant/ Are you Breastfeeding? _____
Have you ever been advised by your doctor to take any antibiotic prophylaxis prior to dental treatment?
_____

Does any of the following apply to you?

AIDS/HIV	Excessive Bleeding	Kidney Diseases	Rheumatic Fever
Allergies	Epilepsy	Leukemia	Sinus Problems
Anemia	Glaucoma	Liver Diseases	Stroke
Angina	Hay Fever	Mitral Valve Prolapse	Seizures
Arthritis	Head Injuries	Mental Disorder	Surgeries
Artificial Joints	Heart Attack	Nervous Disorder	Thyroid Problems
Asthma	Heart Murmur	Other Stomach Problems	Transplants
Blood Diseases	Heart Problems	Pacemaker	Ulcers
Cancer	High Blood Pressure	Prosthetic Valves	Venereal Diseases
Cannabis Use	Hepatitis A/B/C	Rheumatism	
Diabetes	Infective Endocarditis	Respiratory Problems	
Dizziness	Jaundice	Radiation Treatment	

Do you have ANY other medical conditions that are not mentioned above? If yes, please specify.
_____

MEDICATION

List all Medications including dosage that you are currently taking:
_____Pharmacy Name: _____
_____Address: _____
_____Phone: _____

AUTHORIZATION

I, the undersigned patient, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information.
I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics or other prescribed drugs as indicated.
Unless other arrangements are made, payment is due at each office visit. My dental insurance is a contract between myself and the insurance company, not between the dentist and myself.
I will assume full responsibility for the fees associated with these procedures.
I further agree to receive electronic messages including text messages, emails, phone calls, regarding communicating appointments, information, products, promotions, which can be withdrawn at any time.

_____	_____	_____
Patient/Guardian Signature	Dentist's Signature	Date