# WELCOME TO OUR OFFICE

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you.

**PLEASE PRINT.**

## PATIENT INFORMATION

A parent or guardian will be responsible for decisions on my treatment **Yes** ❒ **No** ❒

Name: _____
First Initial Last

Address: _____
Street Apt

_____
City Prov Postal Code

Date of birth: ___/___/___ Cell Tel (___)_____ Home Tel (___)_____
D M Y Work Tel (___) _____

Emergency Contact: _____ Tel ( ) _____

Family Doctor: _____ Tel ( ) _____

Referring Doctor: _____ Tel ( ) _____

Whom may we thank for referring you? _____

## FINANCIAL INFORMATION

Person responsible for financial matters

Self ❒ Spouse ❒ Parent/Guardian ❒ Other ❒

**IF DIFFERENT FROM ABOVE**

Name: _____
First Initial Last

Address: _____
Street Apt City Prov Postal Code

Date of Birth: _____/_____/_____ Home Tel (_____)_____
D M Y

Company: _____ Work Tel (_____)_____

Health Card # _____

## INSURANCE

Ins. Company _____ Tel (_____) _____

Employer/Policy Holder _____ Ins. Yr End _____

Policy # _____ Certificate # _____ ID# _____

Subscriber's Name _____ Subscribers D.O.B. _____

*I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.*

***Signature of patient, parent or guardian:*** _____ *Date:* _____

*I hereby assign my benefits, payable from claims submitted electronically, to Unifor Dental and authorize payment directly to my dentist. This authorizaation shall continue in effect until the undersigned revokes the same.*

***Signature of plan member:*** _____ *Date:* _____

## DENTAL HISTORY

1. What is the reason for today's visit? ❒ Emergency ❒ Examination ❒ Other _____
2. How frequently do you see a dentist? ❒ 3-6 months ❒ Annually ❒ Other _____
3. When was your last dental visit? _____ Last X-Ray? _____
4. How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____
5. Are your teeth sensitive to: ❒ Cold ❒ Sweets ❒ Heat ❒ Other _____

| | YES | NO |
|---|---|---|
| 6. Have you ever had local anaesthetic (freezing)? | ❒ | ❒ |
| Any complications? ❒ Yes ❒ No Specify _____ | | |
| 7. Have you ever had any problems with previous dental treatment? | ❒ | ❒ |
| Specify _____ | | |
| 8. Are you satisfied with your teeth? | ❒ | ❒ |
| Specify _____ | | |

Medical Alert

## MEDICAL HISTORY

(This information will remain confidential)

| | YES | NO |
|---|---|---|
| 1. Are you presently under the care of a physician? | ❒ | ❒ |
| If so explain _____ | | |
| 2. Have you ever been hospitalized or had Surgeries? | ❒ | ❒ |
| Explain _____ | | |
| 3. Are you taking any drugs or medication at this time? | ❒ | ❒ |
| A) Drug _____ Reason _____ | | |
| B) Drug _____ Reason _____ | | |
| C) Drug _____ Reason _____ | | |
| 4. Have you ever had any adverse effects to any of the following: | ❒ | ❒ |
| **Antibiotics - Penicillin ❒, Sulfonamide ❒, Other ❒, Aspirin ❒, Barbiturates (sleeping pills) ❒, Codeine ❒, Darvon ❒, Local Anaesthetic ❒** | | |
| 5. Have you ever been warned against using any other medication? | ❒ | ❒ |
| Which _____ | | |
| 6. Use of alcohol & frequency: _____ | ❒ | ❒ |
| 7. Use of recreational drugs & frequency: _____ | ❒ | ❒ |
| 8. Do you suffer from any allergies (hay fever, latex etc) _____ | ❒ | ❒ |
| 9. Do you bruise easily or have prolonged bleeding? | ❒ | ❒ |
| 10. Do you smoke? How much per day? _____ | ❒ | ❒ |
| 11. Have you ever fainted, had shortness of breath or chest pains? | ❒ | ❒ |

12. WOMEN Are you pregnant? Yes ❒ No ❒ Reached menopause? Yes ❒ No ❒

13. Do you or have you ever had any of the following? Please ✓ appropriate boxes ❒ **None**

| | | |
|---|---|---|
| ❒ A.I.D.S. | ❒ Epilepsy or seizures | ❒ Leukemia |
| ❒ Anemia | ❒ Glandular disorders | ❒ Lung disease |
| ❒ Angina Pectoris | ❒ Glaucoma | ❒ Malignant hyperthermia |
| ❒ Anorexia nervosa | ❒ Head/Neck Injuries | ❒ Mental/nervous disorder |
| ❒ Arthritis/rheumatism | ❒ Heart disease/attack | ❒ Mitral valve prolapse |
| ❒ Artificial heart valve | ❒ Heart murmur | ❒ Organ transplant/implant |
| ❒ Artificial joints (hip, knee) | ❒ Heart pacemaker/surgery | ❒ Psychiatric treatment |
| ❒ Asthma | ❒ Heart rhythm disorder | ❒ Radiation/Chemotherapy |
| ❒ Blood disorders | ❒ Hepatitis A/B/C | ❒ Rheumatic/Scarlet fever |
| ❒ Bronchitis | ❒ Herpes | ❒ Sickle Cell disease |
| ❒ Bulimia | ❒ High/Low blood pressure | ❒ Sinus trouble |
| ❒ Cancer | ❒ H.I.V. Positive | ❒ Stomach/intestinal prob. |
| ❒ Circulation problems | ❒ Hodgkins disease | ❒ Stroke |
| ❒ Congenital heart lesions | ❒ Hyper (Hypo) Glycemia | ❒ Thyroid disease |
| ❒ Cortisone/steroid | ❒ Osteoporosis | ❒ Tuberculosis |
| ❒ Diabetes | ❒ Jaundice | ❒ Ulcers |
| ❒ Drug/Alcohol dependence | ❒ Kidney disease | ❒ Venereal disease |
| ❒ Emphysema | ❒ Liver Disease | ❒ Other |

## GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all the information I have completed is correct and that I have not knowingly omitted information. I consent to the release of medical information from my medical doctor or other health care providers as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Signature _____ Print name _____ Date _____

**Thank you for assistance and patience.**