Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink.

If you have any questions or need assistance, please ask us and we will be happy to help.

elcome

Name S\$#/SIN Birthdate Home Phone S\$#/SIN Address City Prov. P.C.	Patient Information (Confidential)		Patient Number	
Address City Prov Pic Person Contently a Patient in our Office? Work Phone Shafter Sha	Name			
Address City Prov Pic Per	SS#/SIN	Birthdate	Home Phone	
Email	Address	City		
Check Appropriate Box: Minor Single Married Separated Divorced Widowed Statident, Name of School/College City Prov. Full Time Patient or Parent/Guardian's Employer Work Phone States States States States Prov. Ptc. Spouse or Parent/Guardian's Name Employer Work Phone Whom May We Thank for Referring You? Person to Contact in Case of Emergency Phone Responsible Party Relationship To Patient To Patient Address Home Phone Email Cell Phone Driver's License # Birthdate Financial Institution Employer Work Phone SS#/SIN States Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Name of Imployer Union or Local # Work Phone Birthdate SS#/SIN Date Employed Name of Employer Union or Local # Proicy Tele How Much is Your Deductible? How Much Have You Used? Max. Annual Benefit Do You Have Any Additional Insurance? Ves No If Yes, Complete the Following Insurance Company Group # Policy/ID# Date Employer Union or Local # Work Phone States State		•		
If Student, Name of School/College				
Patient or Parent/Guardian's Employer Business Address City Spouse or Parent/Guardian's Name Employer Work Phone State/ Prov. P.C. Prov. P.C. Prov. P.C. Spouse or Parent/Guardian's Name Employer Whom May We Thank for Referring You? Person to Contact in Case of Emergency Responsible Party Name of Person Responsible for this Account Address Home Phone Email Cell Phone Driver's License # Birthdate Financial Institution Employer Work Phone SS#/SIN Is this Person Currently a Patient in our Office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Name of Insured SS#/SIN Date Employed Name of Employer Union or Local # Work Phone State/ PC Insurance Company Group # Policy/ID# State/ PC			State/	
Business Address City State/ Prov. P			Work Phone	
Employer Work Phone			State/ Z Prov. P	ip/ C
Whom May We Thank for Referring You? Person to Contact in Case of Emergency Responsible Party Name of Person Responsible for this Account Address Home Phone Cell Phone Driver's License # Birthdate Financial Institution Employer Work Phone SS#/SIN Is this Person Currently a Patient in our Office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Name of Insured Birthdate SS#/SIN Date Employed Mork Phone SS#/SIN Date Employed Insurance Company Group # Policy/ID# State/ Zig/ Prov. P.C. How Much is Your Deductible? How Much Have You Used? Max. Annual Benefit Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Employer Union or Local # Work Phone State/ Size/ State/ Zig/ Prov. P.C. How Much is Your Deductible? How Much Have You Used? Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Employer Union or Local # Work Phone State/ Size/ State/ P.C. How More Employer Union or Local # Work Phone State/ Size/ Prov. P.C. Insurance Company Name of Employer Union or Local # Work Phone State/ Size/ State/ P.C. Prov. P.C. Insurance Company Name of Employer Union or Local # Work Phone State/ Size/ State/ P.C. Prov. P.C. Insurance Company Group # Policy/ID# State/ P.C. Prov. P.C. Insurance Company Group # Policy/ID# State/ P.C. Prov. P.C. Insurance Company Group # Policy/ID# State/ P.C. Prov. P.C. Insurance Company Group # Policy/ID# State/ P.C.				
Person to Contact in Case of Emergency Phone Responsible Party Name of Person Responsible for this Account to Patient to				
Responsible Party Name of Person Responsible for this Account				
Relationship to Parient Address				
Address				
Birthdate				
Birthdate				
Employer	Driver's License #	Birthdate F		
Is this Person Currently a Patient in our Office?				
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash				
Birthdate SS#/SIN Date Employed Work Phone State/ Prov. P.C. Employer Address City Prov. P.C. Insurance Company Group # Policy/ID# Ins. Co. Address City Prov. P.C. How Much is Your Deductible? How Much Have You Used? Max. Annual Benefit Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Insured SS#/SIN Date Employed Name of Employer Union or Local # Work Phone State/ Zip/ Prov. P.C. Employer Address City Prov. P.C. Insurance Company Group # Policy/ID# State/ Zip/ Prov. P.C. Insurance Company Group # Policy/ID# State/ Zip/ Prov. P.C. Insurance Company City Prov. P.C. State/ Zip/ Prov. P.C. State/ Zip/ Prov. P.C. State/ Zip/ Prov. P.C. Prov. P.C. State/ Zip/ Prov. P.C. Insurance Company Prov. P.C. State/ Zip/ Prov. P.C. State/ Zip/ Prov. P.C. State/ Zip/ Prov. P.C. Prov. P.C. Prov. P.C. State/ Zip/ Prov. P.C. Prov. P.C.	Insurance Information		Relationship	
Name of Employer				
Employer Address City State/ Prov. P.C. Insurance Company Group # Policy/ID# Ins. Co. Address City Prov. P.C. State/ Zip/ Prov. P.C. State/ Zip/ Prov. P.C. State/ Prov. P.C. P.C. State/ Prov. P.C. State/ Prov. P.C. P.C. State/ Prov. P.C. P.C. State/ Prov. P.C. Insurance Company Group # Policy/ID# State/ Prov. P.C. P.C. State/ Prov. P.C. P.C. State/ Prov. P.C. P.C. P.C. Prov. P.C. P.C. P.C. P.C. P.C. P.C. P.C. P.			Work Phone	
Insurance Company Group # Policy/ID#			State/ Z Prov. P	ip/ C.
Ins. Co. Address City State/ Prov P.C State/ Prov P.C City City City Max. Annual Benefit Max. Annual Benefit Max. Annual Benefit Do You Have Any Additional Insurance?			Policy/ID#	
How Much is Your Deductible? How Much Have You Used? Max. Annual Benefit Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Relationship to Patient Birthdate SS#/SIN Date Employed Work Phone Employer Address City Prov. P.C. Insurance Company Group # Policy/ID# State/ Zip/ Prov. P.C. Insurance Company City Prov. P.C.	Ins. Co. Address		State/ Z Prov. P	ip/ .C.
Relationship to Patient		•		
Name of Insured to Patient Birthdate SS#/SIN Name of Employer Union or Local # Work Phone Employer Address City Prov. P.C. Insurance Company Group # Policy/ID# Ins. Co. Address City Prov. P.C.	Do You Have Any Additional Insurance?	No If Yes, Complete the Following		
Date Employed Date Employed	Name of Insured			
Name of Employer Union or Local # Work Phone Employer Address City Prov. P.C. Insurance Company Group # Policy/ID# State/ Zip/ Ins. Co. Address City Prov. P.C.				
Employer Address City State/ Prov Zip/ Prov Insurance Company Group # Policy/ID# Ins. Co. Address City Prov P.C			Work Phone	
Insurance Company Group #				ip/ C
Ins. Co. Address City State/ Zip/ Prov P.C			Policy/ID#	
			State/ Z Prov. P	ip/
HOW MIGHT TO TOU DOUGGED INTO THE PROPERTY OF				

Patient Medical History						
Physician				Date of Last Exam	Yes	No
1. Are very under medical treatment new?	Yes	No	10.	Are you wearing contact lenses?	Tes	
Are you under medical treatment now?				Are you allergic to or have you had any reactions to the following?		
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?				Local Anesthetics (e.g. Novocain)		
If yes, please explain				Penicillin or any other Antibiotics Sulfa Drugs		
				Barbiturates		
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?				Sedatives		
if yes, what medication(s) are you taking?				lodine Aspirin		
4. Have you ever taken Fen-Phen/Redux?				Any Metals (e.g. nickel, mercury, etc.)		
5. Have you ever taken Fosamax, Boniva, Actonel or any				Latex Rubber		
cancer medications containing bisphosphonates?				Other		
6. Have you taken Viagra, Revatio, Cialis or Levitra in			12.	Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?		
the last 24 hours?			12	. Women Only:		
7. Do you use tobacco?			10.	Are you pregnant or think you may be pregnant?		
8. Do you use controlled substances?				Are you nursing?		
9. Do you have or have you had any of the following?				Are you taking oral contraceptives?		
Yes No				Yes No	Yes	No
High Blood Pressure Heart Disease	9			Chest Pains		
Heart Attack Cardiac Pace	maker			Easily Winded		
Rheumatic Fever Heart Murmur	r			Stroke		
Swollen Ankles Angina				Hay Fever/Allergies		
Fainting/Seizures Frequently Tir	ed			Tuberculosis		
Asthma Anemia				Radiation Therapy		
Low Blood Pressure Emphysema				Glaucoma		
Epilepsy/Convulsions Cancer				Recent Weight Loss		
Leukemia Arthritis				Liver Disease		
Diabetes Joint Replace	ment o	r Implant		Heart Trouble		
Kidney Diseases	ndice			Respiratory Problems		
AIDS or HIV Infection Sexually Trans	smitted	Disease		☐ Mitral Valve Prolapse		
Thyroid Problem Stomach Trou	bles/UI	cers		Other		
Patient Dental History						
Name of Previous Dentist and Location				Date of Last Exam		
Yes	s No				Yes	No
Do your gums bleed while brushing or flossing?			8	3. Do you have frequent headaches?		
2. Are your teeth sensitive to hot or cold liquids/foods?			9	B. Do you clench or grind your teeth?		
3. Are your teeth sensitive to sweet or sour liquids/foods?			10	Do you bite your lips or cheeks frequently?		
4. Do you feel pain to any of your teeth?			11	. Have you ever had any difficult extractions in the past?		
5. Do you have any sores or lumps in or near your mouth?			12	2. Have you ever had any prolonged bleeding		
6. Have you had any head, neck or jaw injuries?				following extractions?		
7. Have you ever experienced any of the following			13	3. Have you had any orthodontic treatment?		
problems in your jaw?			14	Do you wear dentures or partials?		
Clicking				If yes, date of placement		
Pain (joint, ear, side of face)			15	i. Have you ever received oral hygiene instructions		
Difficulty in opening or closing				regarding the care of your teeth and gums?		
Difficulty in chewing			16	5. Do you like your smile?		
Authorization and Release						
I certify that I have read and understand the above information to the best of m	v knowl	edne	to t	he dentist or dental group insurance benefits otherwise payable to me. I i	under	etand
The above questions have been accurately answered. I understand that provide	ing inco	rrect	that	t my dental insurance carrier may pay less than the actual bill for service	s. I ag	
information can be dangerous to my health. I authorize the dentist to release ar		nation	res	ponsible for payment of all services rendered on my behalf or my depend	ents.	
including the diagnosis and the records of any treatment or examination render me or my child during the period of such Dental care to third party payors and/o		h	Χ			
practitioners. I authorize and request my insurance company to pay directly			-	nature of patient (or parent/guardian if minor)		
Doctor's Comments						
Signature				Data		
Orginatal 6				Date		