

## Forest City Dental - Patient Information

In order to render an optimum health service, it is necessary to obtain a variety of vital personal information. All information obtained is kept strictly confidential. *Please print all information.*

### Biographical Data

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Title  Mr.  Mrs.  Ms.  Miss  Dr. Birthdate (D/M/Y) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City, Province \_\_\_\_\_

Postal Code \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Single  Married  Separated  Divorced  Widow(er)

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Person responsible for this account \_\_\_\_\_

Do you have dental insurance?  Yes  No

Name of Insurance Carrier \_\_\_\_\_

Policy Number \_\_\_\_\_ Certificate Number \_\_\_\_\_

Who may we thank for your referral? \_\_\_\_\_

### Dental History

When was your last dental visit? \_\_\_\_\_

When did you last have dental x-rays? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

	YES	NO
Have you been seeing a dentist regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Do any of your teeth ache?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been advised to take antibiotics before dental appointments?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been in a vehicle accident or experienced any blows to your jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any implant surgery in your jaws or jaw joints?	<input type="checkbox"/>	<input type="checkbox"/>

Please list anything else not mentioned above regarding your past dental history. \_\_\_\_\_

## Medical History

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_  
OHIP# \_\_\_\_\_

Are you being treated for any medical condition at present or within the last year? YES NO

When was your last medical check-up? \_\_\_\_\_

Has there been any change in your general health in the past year?

Please list *all* medications you are currently taking, both prescription *and* non-prescription.

\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies? (please list) \_\_\_\_\_

Have you ever had an adverse reaction to any medicines or injections?

Do you have any heart or blood pressure problems?

Do you have a heart murmur or mitral valve prolapse?

Have you ever had rheumatic fever?

Do you have or have you ever had jaundice, hepatitis, or liver disease?

Have you ever been told that you should not give blood?

Do you have any conditions that could affect your immune system (e.g. AIDS, HIV, leukemia)?

Do you have a tendency to bruise easily or bleed for a prolonged period of time?

Have you ever been hospitalized for any serious illnesses or operations?

Have you ever had any radiation therapy about the head or neck?

Do you have or have you ever had any of the following? (Please tick off only those that apply.)

- |   |                                   |   |                                    |   |   |
|---|-----------------------------------|---|------------------------------------|---|---|
| <input type="checkbox"/> epilepsy       | <input type="checkbox"/> diabetes | <input type="checkbox"/> bronchitis             | <input type="checkbox"/> asthma    | <input type="checkbox"/> tuberculosis         | <input type="checkbox"/> emphysema        |
| <input type="checkbox"/> heart attack   | <input type="checkbox"/> stroke   | <input type="checkbox"/> stomach ulcers         | <input type="checkbox"/> arthritis | <input type="checkbox"/> prosthetic joint(s)  | <input type="checkbox"/> angina           |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> cancer   | <input type="checkbox"/> drug/alcohol addiction | <input type="checkbox"/> pacemaker | <input type="checkbox"/> psychiatric disorder | <input type="checkbox"/> artificial valve |

Are there any other conditions or diseases not listed above which we should be made aware of?

\_\_\_\_\_  
Do you smoke or chew tobacco?  Yes  No If yes, how much and for how long? \_\_\_\_\_

For women only: are you pregnant?  Yes  No If yes, expected delivery date \_\_\_\_\_

Notes/follow-up information \_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the above information is correct.

\_\_\_\_\_  
(signature of patient)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(reviewed by treating dentist)

\_\_\_\_\_  
(date)

## Forest City Dental - Office Policies

After consenting to treatment, I authorize the dentists of Forest City Dental to perform any dental and oral surgical procedures, including the use of radiographs and drugs, which are necessary for my oral health. I assume responsibility for the fees associated with those procedures.

Our office policy is such that services are paid for as they are rendered at each visit. If you have dental insurance, your carrier will remit payment directly to you. However, under special circumstances arrangements for payment can be made by consulting with the treating dentist and business associates before the treatment is performed.

Please note that your appointment time is especially reserved for you. If you cannot keep the appointment we require 48 hours notice. If we do not receive sufficient notice you will be charged for the lost time. We appreciate that you respect our time as much as we value yours.

I have read and understand the above, and agree to comply with the stated office policies.

\_\_\_\_\_  
(print name of patient)

\_\_\_\_\_  
(signature of patient)

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(date)