

Welcome

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.

Name Date Date S\$#/\$IN Birhdate Home Phone S\$#/\$IN Birhdate Home Phone Stets Zip/ Prov PC.	Patient Informati	Patient Number	Patient Number				
SS#/SIN Birthdate Home Phone Rec Marco Rec	Name						
Address							
Email Cell Phone Check Appropriate Box: Minor Single Married Separated Widowed Widowed Widowed Widowed Widowed Widowed Widowed Widowed Widowed Full Time Part Ti Forum Part Ti Full Time Part Ti Full Time Part Ti				State/ Prov	Zip/ PC		
Check Appropriate Box: Minor Single Married Separated Divorced Widowed State Name of School/College City Work Phone Frow Prov. PRC. State Zip Prov. PRC. State Zip Prov. PRC. Prov. PRC							
If Student, Name of School/College							
Patient or Parent/Guardian's Employer Business Address City Prov. RC. Spouse or Parent/Guardian's Name Employer Work Phone Work Phone Work Phone Work Phone Work Phone Work Phone Person to Contact in Case of Emergency Responsible Party Name of Parson Responsible for this Account Address Email Cell Phone Birthdate Financial Institution Employer Work Phone S\$#/SIN Is this Person Currently a Patient in our Office? Yes No For your convenience, we affer 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 polic Insurance Information Name of Insured S\$#/SIN Date Employer Union or Local # Work Phone Employer Address City Prov. RC. Poolicy/ID# State/ Prov. RC. Poolicy/ID# State/ Do You Have Any Additional Insurance? Yes No Insurance Employer Union or Local # Max. Annual Benefit Name of Insured Birthdate S\$#/SIN Date Employed Nam. Annual Benefit Nam. Annual Benefit Nam. Annual Benefit Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Employer Union or Local # Work Phone State/ State/ Prov. RC. Policy/ID# State/ State/ Prov. RC. Policy/ID# State/ Prov. RC. Prov. RC. Prov. RC. Prov. RC. Policy/ID# State/ State/ Prov. RC. Prov. RC. Prov. RC. Prov. RC. Prov. RC. Policy/ID# State/ State/ Prov. RC. Pr				State/	☐ Full Time ☐ Part Tim		
Business Address City Prov. P.C. 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 Employer 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 polic Insurance Information Relationship to Patient Birthdate SS#/SIN Date Employed Work Phone SS#/SIN Date Employer Vork Phone Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment polic Insurance Information Relationship to Patient Date Employer Union or Local # Work Phone State/ Zip/ Prow. 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 Insured SS#/SIN Date Employed Name of Insured SS#/SIN Date Employed Name of Insurance SS#/SIN Date Employed Name of Insurance SS#/SIN Date Employed Nax. Annual Benefit Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following Name of Employer Union or Local # State/ Zip/ Prow. P.C. Name of Employer Union or Local # State/ Zip/ Prow. Name of Employer Union or Local # State/ Zip/ Prow. P.C. State/ Zip/ Prow. P.C. P.C. Name of Employer Union or Local # State/ Zip/ Prow. P.C. P.C. P.C. Name of Employer Union or Local # State/ Zip/ Prow. P.C. P.C. P.C. Name of Employer Union or Local # State/ Zip/ Prow. P.C. P.C. P.C. Name of Employer Union or Local # State/ Zip/ Prow. P.C. P.C. P.C. Name of Employer Volument Volument Volum							
Spouse or Parent/Guardian's Name				State/ Prov.	Zip/ P.C.		
Whom May We Thank for Referring You? Person to Contact in Case of Emergency							
Person to Contact in Case of Emergency Phone Responsible Party Name of Person Responsible for this Account to Patient t							
Responsible Party Name of Person Responsible for this Account to Person Responsible for Person Responsible for this Account to Person Responsible for this Account to Person Responsible for Person Responsible for this Account to Person Responsible for this Account to Person Responsible for Person Responsible for this Account to Person Responsible for this Account to Person Responsible for this Account to Person Responsible for Person Responsible for this Account to Person Responsible for Person Responsible for this Account to Person Responsible for Person Res							
Name of Person Responsible for this Account to Petient to Potient							
Address		-					
Email							
Driver's License #							
Employer							
Is this Person Currently a Patient in our Office?	Carried Control of Con						
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash	Employer	Work	Phone	SS#/SIN			
Birthdate SS#/SIN Date Employed Name of Employer Union or Local # Work Phone State/ Zip/ Employer Address City Prov. R.C. Insurance Company Group # Policy/ID# State/ Zip/ Ins. Co. Address City Prov. R.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 Relationship to Patient to Patient to Patient to Patient Mome of Employer Union or Local # Work Phone State/ Zip/ Employer Address City Prov. R.C. Insurance Company Group # Policy/ID# State/ Zip/ Ins. Co. Address City Prov. R.C.	Insurance Inforn	nation		Relationship	, c		
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Ins. Co. Address City State/ Prov RC How Much is Your Deductible? How Much Have You Used? Max. Annual Benefit Do You Have Any Additional Insurance?							
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 Name of Employer Union or Local # Employer Address City Prov. Prov. Pc. Insurance Company Ins. Co. Address City Prov. Prov. Pc.				State/	Zip/		
Do You Have Any Additional Insurance? Name of Insured SS#/SIN Date Employed Name of Employer Employer Address Insurance Company Insurance Company State/ City Prov. State/							
Relationship to Patient SS#/SIN Date Employed Mork Phone State/ Zip/ Prov. P.C.	How Much is Your Deductible?	How Much H	ave You Used?	Max. Annual Be	enetit		
Name of Insured to Patient Birthdate SS#/SIN Name of Employer Union or Local # Employer Address City Insurance Company Group # Ins. Co. Address City	Do You Have Any Additional Insu	urance?	☐ No If Yes, Co	mplete the Following			
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.	Name of Insured						
Employer Address City State/Prov. Zip/Prov. Insurance Company Group # Policy/ID# Ins. Co. Address City Prov. Zip/Prov.	Birthdate	SS#/SIN		Date Employed			
Employer Address City Prov. P.C. Insurance Company Group # Policy/ID# Ins. Co. Address City Prov. Zip/ Prov. P.C.	Name of Employer		Union or Local #	Work Phone	7in/		
Ins. Co. Address City State/ Zip/ Prov PC	Employer Address		City	Prov.	P.C		
Ins. Co. Address City Prov P.C	Insurance Company		Group #	Policy/ID#			
How Much is Your Deductible? How Much Have You Used? Max. Annual Benefit				State/	7in/		
					_ P.C		

Patient Medical History	ory _							
Physician				e Date of Last Exam	V	NI		
	2	Yes	No		Yes	No		
1. Are you under medical treatment now				10. Are you wearing contact lenses?	2			
2. Have you ever been hospitalized for a operation or serious illness within the				 Are you allergic to or have you had any reactions to the following: Local Anesthetics (e.g. Novocain) 				
If yes, please explain				Penicillin or any other Antibiotics				
ii yes, piedse expidiri				Sulfa Drugs				
3. Are you taking any medication(s) inclu	ding			Barbiturates				
non-prescription medicine?				Sedatives Iodine	H	-		
If yes, what medication(s) are you taki	ng?			Aspirin				
4 Have you aver taken Een Phon/Pedux)			Any Metals (e.g. nickel, mercury, etc.)				
4. Have you ever taken Fen-Phen/Redux?5. Have you ever taken Fosamax, Boniva, Actonel or any cancer				Latex Rubber	H	-		
medications containing bisphosphona				Other				
6. Have you taken Viagra, Revatio, Cialis	s or Levitra		_	12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?				
in the last 24 hours?				13. Women Only:				
7. Do you use tobacco?				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 Di	sease		Chest Pains				
Heart Attack	☐ ☐ Cardiac		aker	☐ Easily Winded				
Rheumatic Fever	☐ ☐ Heart M	urmur		□ □ Stroke				
Swollen Ankles	☐ Angina			☐ Hay Fever/Allergies				
Fainting/Seizures	Frequent	ly Tire	d	☐ Tuberculosis				
Asthma	☐ Anemia			Radiation Therapy				
Low Blood Pressure	☐ Emphyse	ema		☐ Glaucoma				
Epilepsy/Convulsions	☐ Cancer			Recent Weight Loss				
Leukemia	Arthritis			Liver Disease				
Diabetes	☐ ☐ Joint Rep	olacem	ent or Impl	ant Heart Trouble				
Kidney Diseases	Hepatitis			Respiratory Problems				
AIDS or HIV Infection			nitted Disec					
Thyroid Problem	☐ ☐ Stomach	Troub	les/Ulcers	Other				
Patient Dental Histo	rv							
	-			D (1 - 1 - 1				
Name of Previous Dentist and Locat		V	NI-	Date of Last Exam	V	NI		
1. Do your gums blood while brushing a		res	INO		Yes	N		
 Do your gums bleed while brushing or flossing? Are your teeth sensitive to hot or cold liquids/foods? 				8. Do you have frequent headaches?9. Do you clench or grind your teeth?		-		
Are your teeth sensitive to sweet or sour liquids/foods?				10. Do you bite your lips or cheeks frequently?	H			
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				12. 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. Have you had any orthodontic treatment?				
problems in your jaw?	0			14. Do you wear dentures or partials?				
Clicking				If yes, date of placement				
Pain (joint, ear, side of face)				15. Have you ever received oral hygiene instructions				
Difficulty in opening or closing				regarding the care of your teeth and gums?				
Difficulty in chewing				16. Do you like your smile?				
Authorization and Rele	ase							
I certify that I have read and understand th		no hast	of my	my insurance company to pay directly to the dentist or dental group insurar	nce			
knowledge. The above questions have bee				benefits otherwise payable to me. I understand that my dental insurance ca		may		
that providing incorrect information can be				pay less than the actual bill for services. I agree to be responsible for paym	ent c	of all		
dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such				services rendered on my behalf or my dependents.				
Dental care to third party payors and/or he				X				
				Signature of patient (or parent/guardian if minor)	170			
Doctor's Comments			Y ments			-		
						_		
		Signat		Data				