PERSONAL INFORMATION

* **Instructions:**

1. The fields marked by star (*), are required and must be filled out.
2. If you have any questions or need clarification regarding the form, please do not hesitate to call our office at 416-221-6621.

First Name* _____ Last Name* _____ Date of Birth* ___/___/___
MM/DD/YYYY

Address* _____ City* _____ Postal Code* _____

Cell Phone* _____ Home Phone* _____ Occupation* _____

Email* _____

Please indicate preferred time of day, or special considerations: _____

EMERGENCY INFO

Emergency Contact - Name:* _____ Relationship : _____

Phone Numbers :* (C): _____ (W): _____ (H): _____

Family Physician - Name: _____ Office Phone: _____

Specialist - Name: _____ Specialty: _____ Office Phone: _____

PATIENT INFORMATION

How can we help you?

☐ Comprehensive Exam ☐ Pain Relief/ Emergency ☐ Dental Hygiene/Cleaning ☐ Consultation

What is your chief concern? _____

How did you hear about us?

_____

When was your last Dental visit?* ___/___ When was your last Medical check-up?* ___/___
MM/YYYY MM/YYYY

Are you unhappy with the appearance of your teeth?* ◯ Yes ◯ No

Are you nervous about dental treatment?* ◯ Yes ◯ No

DENTAL INSURANCE INFORMATION (If applicable)

Primary Insurance:

Insured Name: First : _____ Last : _____ Insured Date of Birth* ___/___/___
MM/DD/YYYY

Insured Employer: _____ Insurance Company: _____

Plan or Group : _____ Certificate/Member ID #: _____

Relationship to Insured: _____ Insured Cell Phone: _____

Secondary Insurance (if available):

Insured Name: First : _____ Last : _____ Insured Date of Birth* ___/___/___
MM/DD/YYYY

Insured Employer: _____ Insurance Company: _____

Plan or Group : _____ Certificate/Member ID #: _____

Relationship to Insured: _____ Insured Cell Phone: _____

MEDICAL HISTORY

Do you have tendency to bruise easily or bleed for a prolonged period of time?* ◯ Yes ◯ No

Have you ever had or are receiving Chemo or Radiation Therapy?* ◯ Yes ◯ No

Have you been instructed by your physician to take antibiotics prior to dental treatment?* ◯ Yes ◯ No

Are you currently being treated for any Medical conditions? * ◯ Yes ◯ No

Are you taking any Medications (including blood thinners) or Non-Prescription Drugs?* ◯ Yes ◯ No

Please List: _____

Have there been any recent changes in your general health? Have you recently gained or lost an excessive amount of weight?* ◯ Yes ◯ No

Explain: _____

Have you ever been seriously ill, hospitalized or had any major surgery?* ◯ Yes ◯ No

Have you ever had an adverse reaction to any medications?* ◯ Yes ◯ No

Please List: _____

Do you have allergies* ◯ Yes ◯ No

Please List: _____

Do you carry an Epipen?* ◯ Yes ◯ No

Do you have or ever had the following?*

- ☐ AIDS/ HIV Positive
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Chest Pain/Angina
- ☐ Hepatitis
- ☐ Sinusitis
- ☐ Diabetes
- ☐ Cancer
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Heart Murmur
- ☐ Bronchitis
- ☐ Psychiatric disorders
- ☐ Steroid Therapy
- ☐ Nausea
- ☐ Asthma
- ☐ Pacemaker
- ☐ Stomach Ulcer
- ☐ Drug/Alcohol dependency
- ☐ Seizures (epilepsy)
- ☐ Fainted
- ☐ Heart Attack/Condition
- ☐ Mitral Valve Prolapse
- ☐ Liver Disease
- ☐ Smoke/Vape heavily
- ☐ None

Do you currently have, or have had any conditions or diseases not listed above* ◯ Yes ◯ No

Please List: _____

Are you experiencing any of the following:*

☐ Grinding/Clenching ☐ Pain/Tenderness in Jaw ☐ Bleeding Gum ☐ Bad Breath ☐ Migraines ☐ Frequent Headaches

Other: _____

For Woman Only :*

☐ Taking birth control ☐ Breast Feeding ☐ Pregnant (How many weeks:_____)

PATIENT CONSENT* (Required)

☐ I understand my personal & clinical information will be kept strictly confidential in accordance with privacy regulations. I understand this information may be shared with other dental specialists for treatment purposes.

☐ I acknowledge that I am financially responsible for services rendered and acknowledge payments are due upon completion of those services. I also acknowledge that dental insurance may not fully cover all procedures, and I am responsible to pay this amount.

☐ I acknowledge that when an appointment is scheduled, a treatment room, along with doctor & staff time is reserved just for me. As a courtesy to our time and dedication, we require two (2) business days notice to change or cancel your appointment. Except in extreme circumstances, a **No Show** or **Short Notice Cancellation Fee** may apply.

☐ I certify that I have read, understood and have accurately completed this form. I will notify staff of any new, or changes to my prescriptions or medical history.

Patient/Parent/Guardian Signature* _____ Date* ___/___/___
MM/DD/YYYY

Dentist Signature* _____ Date* ___/___/___
MM/DD/YYYY

DENTIST'S NOTES: