CLIFFSIDE PLAZA
DENTAL OFFICE

2451 Kingston Road
Scarborough, ON M1N 1V4
(416) 265-3368

WELCOME

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

1 ABOUT YOU

○ Miss ○ Ms ○ Mr ○ Master ○ Mrs Birthdate: MM / DD / YY

First Name _____ Last Name _____

Address _____ Apt. _____ City _____ Postal Code _____

Other family member seen by us? ○ Yes ○ No Whom may we thank for referring you? _____

Home Phone ( ) _____ Cellular/Pager ( ) _____

Work Phone ( ) _____ ○ Self ○ Spouse ○ Mom ○ Dad

Occupation _____ When is the best time to reach you? _____

E-mail _____ Health Card# _____

2 PERSON RESPONSIBLE FOR ACCOUNT

○ As Above

Name _____ Relationship _____

Address _____ Apt. _____ City _____ Postal Code _____

Home Phone ( ) _____ Cellular/Pager ( ) _____

Work Phone ( ) _____ E-mail _____

3 DENTAL INSURANCE

Do you have dental insurance through: Your employer? ○ Yes ○ No Spouse's Employer? ○ Yes ○ No

○ Mom ○ Dad ○ Other _____

4 FOR CASH ACCOUNTS

Driver's Licence: _____ ○ Visa ○ Mastercard ○ AMEX

Credit Card No.: _____ Expiry: _____

5 ALTERNATE CONTACT PERSON

In case of an emergency, is there someone we could contact who DOES NOT LIVE WITH YOU?

Relationship _____ Name _____

Home Phone ( ) _____

6 DENTAL HISTORY

What is the reason for today's visit? ○ Emergency ○ Examination ○ Other _____

How frequently do you see a dentist? ○ 3-6 months ○ Annually ○ Other _____

When was your last dental visit? _____ Last X-Ray? _____

How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____

Are your teeth sensitive to: ○ Cold ○ Sweets ○ Heat

Do your gums bleed when: ○ Brushing ○ Flossing ○ Never

Do your jaws crack or pop when you open widely? ○ Yes ○ No

Do you have food catch between your teeth? ○ Yes ○ No

Have you ever had local anaesthetic (freezing)? ○ Yes ○ No

Any complications with freezing? ○ Yes ○ No

Are you satisfied with your teeth? ○ Yes ○ No Specify _____

7 Medical History

Physician's Name _____ Phone ( ) _____

Are your currently under the care of a physician? ○ Yes ○ No

If yes, please explain _____

Are you presently taking any drugs, prescription, over the counter, herbal? ○ Yes ○ No

If yes, please list: Drug _____ Reason _____

Drug _____ Reason _____

Drug _____ Reason _____

Drug _____ Reason _____

Drug _____ Reason _____

Drug _____ Reason _____

Have you been told to take antibiotics before dental work? ○ Yes ○ No

WOMEN ONLY: Are you pregnant? ○ Yes ○ No Week # _____

Have you ever had any of the following diseases or medical problems (Please circle your answer Yes / Unsure / No)

Y ? N Heart Attack / Stroke / Angina	Y ? N Heart Murmur	Y ? N Rheumatic Fever
Y ? N Heart Surgery / Pacemaker	Y ? N Mitral Valve Prolapse	Y ? N Artificial Heart Valves
Y ? N Congenital Heart Disease	Y ? N Artificial Bones / Joints	Y ? N Sinus Problems
Y ? N High / Low Blood Pressure	Y ? N Cancer/Chemotherapy/Radiation	Y ? N HIV+ / AIDS
Y ? N Liver Disorder	Y ? N Severe / Frequent Headaches	Y ? N Smoker / Chewing tobacco
Y ? N Epilepsy / Seizures / Fainting	Y ? N Diabetes	Y ? N Drug / Alcohol Abuse
Y ? N Hemophilia / Abnormal Bleeding	Y ? N Ulcers / Colitis / GERD	Y ? N Anemia
Y ? N Asthma / Difficulty Breathing	Y ? N Arthritis (Rheumatoid, Osteo)	Y ? N Kidney Problems
Y ? N Emphysema	Y ? N Glaucoma	Y ? N Tuberculosis (TB)
Y ? N Mental / Nervous Disorders	Y ? N Depression	Y ? N Autoimmune Disease
Y ? N Eating Disorders (Anorexia, Bulemia)	Y ? N Osteoporosis / Osteopenia	Y ? N Herpes (Cold sore)
Y ? N Thyroid Disease	Y ? N Hepatitis A / B / C	

Are there other serious medical conditions not listed above? ○ Yes ○ No Please list: _____

_____

Are you allergic to any of the following drugs?

Y ? N Penicillin	Y ? N Dental Anesthetics (freezing)	Y ? N Tetracycline
Y ? N Erythromycin	Y ? N Aspirin	Y ? N Codeine

Are you allergic to any other drugs, metals or materials? ○ Yes ○ No Please list: _____

_____

8 General Release

I, the undersigned, understand that the information contained in the medical and dental history is private and confidential. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable. I understand that fees for treatment may exceed my dental insurance benefits and that I am responsible to the dentist for any portion of claims not covered by my dental plan for myself and my dependents. I authorize my insurance claims to be submitted electronically where applicable.

_____ _____ _____

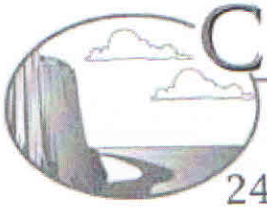
Signature ○ Self ○ Parent/Guardian Print Name Date

Payment is due in full at the time of treatment unless prior arrangements have been made.

Office Use Only

_____

_____



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Missed Appointments/ Insufficient Notice of Cancellation Policy

Important news about our office policy that affects you as a patient.

Please note that your appointment time is reserved especially for you and reflects the amount of time required to tend to your dental needs. In order to respect your time, we strive to stay on schedule. In return, we ask that you respect our time by keeping your scheduled appointment.

In case of cancellations, please speak with one of our receptionists directly. We require **24 bussiness hours** notice to avoid a charge to your account. Please note that a **minimum $50.00** fee may be charged for missed appointments or for insufficient notice of cancellation. Every effort will be made by our reception team to reschedule your appointment in a timely manner.

As always, we will continue our professional service to you and your family as a pledge of our ongoing commitment to your oral health.

Thank you.

ACKNOWLEDGEMENT:

I have read and understand the above information, and I agree to follow your office policy.

_____

Patient Name **Signature** **Date**