

## **Personal Information**

Name: (first and last)					
Preferred Name:		Mr. Ms. Mrs. Miss. Dr. (circle one)			
Home Address:		Contact Information:			
Number and Street:		Home Phone:			
Unit:	City:	Work Phone:			
Postal Code:		Cell Phone:			
Date of Birth: (dd/mm/yyyy):		Email address:			
Preferred method of communication (circle)		Occupation:			
Home phone work phone cell phone					
Emergency Contact Name:		Emergency Contact Phone Number;			
Relationship to Patient:		Family member responsible for this account:			
Who can we thank for re	eferring you?				

# **Insurance Information**

Name of policy holder:		Relationship to patient:		
Address:				
Date of Birth (dd/mm/yyyy):				
Insurance Company:		Employer:		
Division: Policy/Group:			Certificate ID:	
Name of Secondary policy holde	er:(if applicable)			
Address:				
Date of Birth (dd/mm/yyyy):		Relationship to patient:		
Insurance Company:		Employer:		
Division:	Policy/Group:		Certificate ID:	



## **Medical Information**

Please list any medical conditions for which you are being treated or have been treated for:  Approximate date of last medical check-up:  Please list any medications or herbal supplements you are currently taking:  Medications:  Reason:  Do you have an allergy to any of the following (please check)?  Penicillin  Medications:  Do you have an allergy to any of the following (please check)?  Penicillin  Medications:  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have an allergy to any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following (please check)?  Do you have any of the following						
Approximate date of last medical check-up:    Please list any medications or herbal supplements you are currently taking:   Medications:   Reason:	Physician: (name and phone)		Physician: (address)			
Approximate date of last medical check-up:    Please list any medications or herbal supplements you are currently taking:   Medications:   Reason:						
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Please list any medications or herbal supplements you are currently taking:  Medications:  Reason:  Do you have an allergy to any of the following (please check)?  Penicillin  Codeine  Metals  Sulfonamide  General Anesthetic  Other  Please indicate if you have or have ever had any of the following conditions (please check)  Blood Pressure  Heart Transplant  Heart Transplant  Blood Pressure  Heart Conditions  Bleeding Problems or bruise  Easily  Other Heart Valve  Alcohol/Drug Dependence  Compromised Immune  System  Artificial Joint (date of surgery)  Artificial Joint (date of Stomach Problems  Thyroid Problems  Thyroid Problems  Do you have any of the following conditions (please check)  Congenital Heart Disease  Jaundice/Hepatitis/Liver Disease  Cancer (indicate type):  Cancer (indicate type):  Cancer (indicate type):  Chemotherapy/Radiation  Chemotherapy/Radiation  Tuberculosis  Do you have any other medical conditions of which the dentist or hygienist should be aware?	Please list any medical	conditi	ions for which you	ı are being treated	d or ha	ve been treated for:
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Reason:	rippi ominate date of las	Je III ou	iour officerr up:	om n		
Reason:	Please list any medicati	ons or	herbal supplemen	nts you are currer	ntly tak	ing:
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<ul> <li>Blood Pressure</li> <li>Heart Transplant</li> <li>Infective Endocarditis</li> <li>Other Heart Conditions</li> <li>Bleeding Problems or bruise</li> <li>Stroke</li> <li>Prosthetic Heart Valve</li> <li>Alcohol/Drug Dependence</li> <li>Compromised Immune</li> <li>Cocaine/Amphetamine use</li> <li>Emphysema/COPD</li> <li>Artificial Joint (date of surgery)</li> <li>Epilepsy</li> <li>Thyroid Problems</li> <li>Tuberculosis</li> <li>Do you have any other medical conditions of which the dentist or hygienist should be aware?</li> </ul>	o Metals	0	Sulfonamide	o General Ane	esthetic	o Other
<ul> <li>Blood Pressure</li> <li>Heart Transplant</li> <li>Infective Endocarditis</li> <li>Other Heart Conditions</li> <li>Bleeding Problems or bruise</li> <li>Stroke</li> <li>Prosthetic Heart Valve</li> <li>Alcohol/Drug Dependence</li> <li>Compromised Immune</li> <li>Cocaine/Amphetamine use</li> <li>Emphysema/COPD</li> <li>Artificial Joint (date of surgery)</li> <li>Epilepsy</li> <li>Thyroid Problems</li> <li>Tuberculosis</li> <li>Do you have any other medical conditions of which the dentist or hygienist should be aware?</li> </ul>	Please indicate if you ha	ave or	have ever had any	of the following	conditi	ons (please check)
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<ul> <li>Stroke</li> <li>Prosthetic Heart Valve</li> <li>Alcohol/Drug Dependence</li> <li>Compromised Immune</li> <li>Cocaine/Amphetamine use</li> <li>Emphysema/COPD</li> <li>System</li> <li>Diabetes</li> <li>Artificial Joint (date of surgery)</li> <li>Epilepsy</li> <li>Kidney Disease</li> <li>Thyroid Problems</li> <li>Tuberculosis</li> <li>Do you have any other medical conditions of which the dentist or hygienist should be aware?</li> </ul> Female Patients					0	
<ul> <li>Prosthetic Heart Valve</li> <li>Compromised Immune</li> <li>Cocaine/Amphetamine use</li> <li>Emphysema/COPD</li> <li>Cancer (indicate type):</li> <li>Artificial Joint (date of surgery)</li> <li>Epilepsy</li> <li>Kidney Disease</li> <li>Thyroid Problems</li> <li>Tuberculosis</li> <li>Do you have any other medical conditions of which the dentist or hygienist should be aware?</li> </ul> Female Patients		ons		oblems or bruise	0	
O Compromised Immune System O Diabetes O Artificial Joint (date of surgery) O Epilepsy O Thyroid Problems O Do you have any other medical conditions of which the dentist or hygienist should be aware?  Cancer (indicate type): Cancer (indicate type): Chemotherapy/Radiation					0	
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Female Patients	J					
	o Do you have any oth	er medi	cal conditions of whic	th the dentist or hygic	enist sho	ould be aware?
	Female Patients					
		ant		o Currently	Breas	t Feeding



## **Dental Information**

Previous Dentist:	Located in (town/city):	
When was your last dental visit?	Treatment provided?	
When did you last have dental x-rays?	Last cleaning?	
If you have been seeing a dentist regularly, how often were your cleanings?		
How often do you brush your teeth?  How often do you floss your teeth?		
Do you have any specific concerns about your oral health? (expl	ain)	

#### Please circle the following (yes or no)

Do you require antibiotic pre-medication prior to a dental cleaning or treatment (due to heart condition	Yes	No
prosthetic joint, etc.?		
Do you wear any form of dentures?	Yes	No
Is there discomfort associated with any of your teeth?	Yes	No
Do your gums bleed when you brush?	Yes	No
Do you have any pain when you chew?	Yes	No
Do you clench or grind your teeth?		No
Do you snore or have Obstructive Sleep Apnea?		No
Do you have any missing teeth that you would like to investigate replacing?		No
Have you sustained any injury to your jaw (sports, accident, etc.)?		No
Have you ever had dental implant surgery?	Yes	No
Is a dental specialist currently treating you? (explain)		
Would you like to learn more about whitening or cosmetic dentistry options?		No
Are you anxious or fearful about dental appointments?		
If so, rate your anxiety as (circle one): Mild Moderate Severe		
Please add anything else relevant about your dental history:		·

**General Consent Statement:** I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatments to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all-inclusive.

I agree the Georgetown Dental Clinic has obtained informed consent from me with respect to the collection, use and disclosure of my personal information. I have been provided with a copy of the Privacy Code and agree that personal information may be collected, used and disclosed as set out in the Code and is in accordance with the Personal Health Information Protection Act, 2004.

I am aware that missing an appointment or failing to give 24 hours' notice for a cancellation may result in a cancellation fee.

Consent to Electronic Submission of Insurance Claims: I authorize release, to my benefits plan administer and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of service described to Georgetown Dental Clinic. This authorization shall continue until the undersigned revokes the same.

Patient/Parent or Guardian Signature:	Date: