NEW PATIENT INTAKE FORM

Our office requires at least 48 hours notice for all cancellations and/or appointment changes. Failure to provide an adequate notice will result in late cancellation fee of $50 which must be settled before booking any future appointments. Initial:______________

Last Name:____
Given Name:______________________________________
Preferred Name:________________________________
Date of Birth: Day_____ Month ______ Year ________ Gender: ___________________
Address:____
City, Prov:___________________ Postal Code:__________________
Mobile Phone:___________________________________
Email:____

Primary method of contact: ____Email _____Phone
Emergency Contact:______________________Phone Number:________________________
Dental Insurance Company:______________________
Policy #:_____________________ ID#:____________________________________
Occupation:____
Employer/Company Name:______________________________
How did you hear about our office?____

MEDICAL HISTORY:
Family Doctor:_________________________Phone#: ______________________________

1. Are you presently undergoing treatment under the care of a physician for any reason? YES/ NO
If yes, please explain:
____
____

2. Are you currently taking any medications or drugs? YES NO
If yes, please specify:
1) Drug____________________________Reason______________________________
2) Drug____________________________Reason______________________________
3) Drug____________________________Reason______________________________
4) Drug____________________________Reason______________________________

3. Do you need Antibiotics for dental treatment? YES NO
If yes,
explain____
4. Are you allergic to any medications or drugs? YES NO
If yes, explain____
5. Do you have any other allergies? YES NO
If yes, explain____
6. Have you ever had a serious illness, operation, or been hospitalized? YES NO If yes,

explain____
7. Do you bleed or bruise abnormally? YES NO
8. WOMEN: Are you pregnant? YES NO Due date: ______________________________________
9. Do you have or have you ever had any of the following? (Please circle)

Heart disease	Chest pains	Cancer/tumors	Hearing impaired
High blood pressure	Anemia	Intestinal disease	Sign impaired
Low blood pressure	Asthma	Kidney disease	Speech impaired
Heart murmur	Breathing problems	Artificial joints	Learning disability
Pacemaker	Hepatitis	AIDS/HIV	
Rheumatic fever	Thyroid disease	Venereal disease	
Diabetes	Tuberculosis	Depression/Anxiety	
Blood disorders	Epilepsy	Radiation therapy	

10 Is there anything else regarding your health history not previously mentioned? YES NO If yes, explain____

DENTAL HISTORY

Previous Dentist___________________________________
Phone#_____________________________

1.When was your last dental visit?____
2. Have you had dental x-rays in the last year? YES NO
3. Have you ever had local anesthesia for dental treatment? YES NO
If yes, any complications?____
4.Do you presently have any pain? YES NO
If yes, explain____
5. Are any teeth sensitive to HOT___ COLD___ SWEET___ other___
6.Do your gums bleed when brushing or flossing? YES NO
7. Do your gums feel swollen or tender? YES NO
8. Are you happy with the appearance of your smile? YES NO
If no, what would you change?____________
9.Have you ever had a bad dental experience? YES NO
If yes, please explain__________________________

PATIENT CERTIFICATION AND CONSENT TO TREATMENT

I, the undersigned, certify that all of the above medical and dental information is true to the best of my knowledge and I have not omitted any pertinent information. I give consent, to allow any diagnostic and basic dental services, deemed to be necessary to reach a complete and proper diagnosis of my oral health.

Our goal is to help you keep your teeth and gums healthy for a lifetime. Our office will recommend treatment according to your dental health needs. Our recommendation may not always coincide with your insurance coverage. We do believe however, it is in your best interest not to compromise our recommendations based on possible limitations of insurance benefits that may be considerably less than optimal.

<u>For patients with dental insurance</u>: You are responsible for paying any portion (co-payment) that the insurance company does not cover upon completion of treatment. I nearby assign my benefits payable from my insurance to my dentist and authorize payment directly to him/her.

<u>For patients without dental insurance</u>: Payment for your dental services is expected upon the completion of treatment. For major treatment financing may be available.

____ ____
Signature Date