WELCOME TO OUR DENTAL OFFICE

MEDICAL ALERT

The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Privacy Act standards set up and monitored by our office.

Mr.☐ Mrs.☐ Miss☐ Ms.☐ Dr.☐ ☐ADULT ☐CHILD **Marital Status:** ________

Name: (Last) (First) (Initial) ________ Prefer to be Called ________

Address: (Street) (Apt.) (City) (Postal Code)

Home Phone: (_____) ______ - __________ Work Phone: (_____) ______ - __________ X ____ Date of Birth: ____/____/____

Fax: (_____) ______ - __________ Other: (_____) ______ - __________ X ____ ☐ Male ☐ Female

Employer / School: ________________ Occupation: ________________

eMail ID: ________________ Who may we thank for referring you to this office?: ________________

Are you likely to be available on short notice for future appointments or appointment changes? • Yes • No

Family Physician: ________________ Phone: (_____) ______ - __________

In Case of Emergency Notify: ________________ Relation: __________ Phone: (_____) ______ - __________

Person responsible for this account ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: ________

Name: (Last) (First) (Initial) ________ Relation: ________

Address: (Street) (Apt.) (City) (Postal Code)

Home Phone: (_____) ______ - __________ Work Phone: (_____) ______ - __________ X ____ Drivers License Number

Primary Insurance

Subscriber: ________ Date of Birth: ________

Relation: ☐ Self ☐ Spouse Other: ________

Insurance Co: ________

Policy/Plan #: ________ Division/Sect. #: ________

Subscriber I.D. ________ SIN ________

Are you Familiar with Your Plan Details? ☐ Yes ☐ No

Secondary Insurance

Subscriber: ________ Date of Birth: ________

Relation: ☐ Spouse Other: ________

Insurance Co: ________

Policy/Plan #: ________ Division/Sect. #: ________

Subscriber I.D. ________ SIN ________

Are you Familiar with Your Plan Details? ☐ Yes ☐ No

Method of Payment ☐ Cash ☐ Cheque ☐ Credit Card: ________ Number: ________ Exp.: ________

MEDICAL HISTORY

ALL INFORMATION IS CONFIDENTIAL

The following information is required by the dentist to assist in proper diagnosis and treatment. YES NO

1. Have you ever had a serious illness requiring hospitalization or extensive medical care? ☐ ☐
   Please specify: ________________
2. Are you presently under the care of a physician? ☐ ☐
   If so, please explain: ________________
3. Have you had a medical examination in the last year? ☐ ☐
4. Do you use any prescription or non-prescription drugs regularly: ☐ ☐
   Please specify: ________________
5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex? ☐ ☐
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? ☐ ☐
   Please specify: ________________
7. Have you been hospitalized in the last 5 years: ☐ ☐
   Please specify: ________________
8. Have you ever experienced any unusual reaction to any of the following? (Please circle) ☐ ☐
   local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine? If so please explain ________________
9. Have you been warned against taking any drug or medicine? ☐ ☐
10. Do you bruise easily or bleed abnormally? ☐ ☐
11. Do you require pre-medication for dental treatment? ☐ ☐

PATIENT REGISTRATION PLEASE COMPLETE BOTH SIDES **MEDICAL / DENTAL HISTORY**

FORM 102441 N/04/06 ITEM 8101

	Yes	No
12. Have you ever had any organ implants or medical implants?	☐	☐
13. Have you ever fainted?	☐	☐
14. Do your ankles swell?	☐	☐
15. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
16. Do you have frequent headaches?	☐	☐
17. Do you have A.I.D.S. or have you ever tested positive for H.I.V..	☐	☐
18. Do you have any of the following? Please check any that apply	☐	☐

☐ Heart Murmur of Mitral Valve Prolapse	☐ Malignant Hyperthermia	☐ Epilepsy or Seizures	☐ Herpes
☐ Stomach / Intestinal Problems / Ulcers	☐ Drug / Alcohol Dependency	☐ Liver Disease	☐ Sinus Trouble
☐ Joint Replacement (hip, knee, etc.)	☐ Venereal Disease	☐ Heart Attack	☐ Stroke
☐ Mental or Nervous Disorder	☐ Lung Disease (i.e. Asthma)	☐ Cold Sores	☐ Kidney Problems
☐ High Blood Pressure	☐ Thyroid Disease	☐ Jaundice	☐ Emphysema
☐ Low Blood Pressure	☐ Arthritis or Rheumatism	☐ Tuberculosis	☐ Glaucoma
☐ Hyper (hypo) Glycemia	☐ Scarlet or Rheumatic Fever	☐ Hepatitis A,B,C	☐ Diabetes
☐ Cortisone/Steroid Therapy	☐ Cancer / Chemotherapy	☐ Other: ____________	

	Yes	No
19. Have you had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐
20. Do you have any disease, condition, or problem that you think the doctor should know about?	☐	☐
21. WOMEN ONLY - Are you pregnant or suspect that you might be? if so, what month are you in? ____________	☐	☐
Are you taking birth control pills?	☐	☐
Are you nursing?	☐	☐

DENTAL HISTORY

	Yes	No
1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other ____________		
Are you presently having dental pain?	☐	☐
Is there a dental problem you would like to take care of as soon as possible?	☐	☐
Please specify: ____________		
2. How frequently do you see your dentist? ☐ 6 months ☐ Yearly ☐ Other ____________		
Last dental visit: ____________		
Last cleaning: ____________ Full mouth series of x-rays: ____________		
3. How often do you brush your teeth? ____________ Floss? ____________		
4. Do your gums bleed easily?	☐	☐
5. Are you teeth sensitive to: ☐ Hot ☐ Cold ☐ Biting ☐ Sweets?	☐	☐
6. Do you feel you have bad breath at times?	☐	☐
7. Have you ever had jaw joint surgery?	☐	☐
8. Do you have pain in your jaw joints or suffer from migraine headaches?	☐	☐
9. Does any part of your mouth hurt when clenched?	☐	☐
10. Does your jaw crack or pop when opened widely?	☐	☐
11. Have you had: ☐ Braces ☐ Oral surgery ☐ Gum treatment ☐ Root canal	☐	☐
12. Do you grind or clench your teeth during the day or night?	☐	☐
13. Do you smoke? Number per day: ____________	☐	☐
14. Do you or does any family member have a problem with snoring?	☐	☐
15. Have you ever experienced any growths or sore spots in your mouth? If so, where? ____________	☐	☐
16. Previous problems with dental treatment? Specify: ____________	☐	☐
17. Are you satisfied with the appearance of your teeth?	☐	☐
Please specify: ____________		
18. Other Dental Concerns: ____________		

Privacy Act Notification: I have been informed of the privacy policy of this office and understand that all information I have supplied will be used and disclosed as set out within this office policy.

Office Policy: Your appointment time will be reserved for you. If you are unable to keep the appointment we will require 24 hours notice, otherwise it may be necessary to charge for the time lost.

Patient Release: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and to receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependents is mine, and I will assume responsibility for fees associated with these services.

____________ Date: MMM / DD / YY

(Signature) ☐ PATIENT ☐ PARENT ☐ GUARDIAN

REVIEWING DENTIST

Urban Smiles Family Dental

Dental insurance is a contract between your employer and an insurance company. Benefits that you will receive are based on the terms of the contract that was negotiated between your employer and the insurance company.

Unfortunately, some of the services that you may need or want will not be covered by your insurance company. Our goal is to help you achieve and maintain optimal dental health, which is not necessarily the goal of your insurance.

Currently at Urban Smiles Family Dental we accept assignment of benefits. We allow 30 days for your insurance to make payment to us. However, we must stress the fact that ultimately you are responsible for the total treatment fee.

The team at Urban Smiles Family Dental has made a commitment to ensure the best possible service for you at each appointment. If you do not show up for a scheduled, confirmed appointment you are subject to a charge. After this happens twice, we will be happy to forward your records to your new dentist.

____________________________ ____________________________

Date Patient/Guardian

Urban Smiles Family Dental

Patient Privacy Consent Form

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate use and protection of your information

- To deliver safe and efficient patient care
- Only necessary information is collected about you
- We only share your information with your consent
- To communicate with other treating healthcare providers including specialists and referring doctors
- To invoice for services
- To process credit card payments
- To collect unpaid accounts
- Storage, retention, and destruction of your personal information complies with existing legislation and privacy protocols

By signing this consent form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance

________________________ ________________________

Date Patient/Guardian