Date: _____/_____/_____
Day month year

CONFIDENTIAL PATIENT INFORMATION

Dr. Mr. Mrs. Miss Ms.
Family Name: _____ **Given Name:** _____ **Birth Date** _____/____/____
day month year

Address: _____
Street City Postal Code

Tel. H.: ( ) _____ **W.**: ( )_____ Ext.:_____ **Cell:** _____

E-Mail address_____ **Health Card #** _____

Contact in case of emergency _____ **Tel.** _____
Name of spouse, guardian or other: _____Tel. _____
Address: (if different than above) home work

_____
Street City Postal Code

Insurance Information

Primary insurance

Name of Insured: _____ _____ Date of Birth: _____/_____/_____
Last First day month year

Place of Employment: _____ **Insured with** (Ins. Co. Name)_____

Group #:_____ **ID #:** _____ **Extended Health Care Plan:** ☐ Yes ☐ No

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____ **Is insured a patient** ☐ Yes ☐ No

Secondary Insurance

Name of Insured: _____ _____ Date of Birth: _____/_____/_____
Last First day month year

Place of Employment: _____ **Insured with** (Ins. Co. Name)_____

Group #:_____ **ID #:** _____ **Extended Health Care Plan:** ☐ Yes ☐ No

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____ **is insured a patient**? ☐ Yes ☐ No

Dental History

Dentist: _____ **Date of your last appointment**: _____/_____/_____
day month year

- **Yes No** Have you experienced any problems with **local anesthetic**?
- **Yes No** Are you very **nervous** about **dental treatment**?
- How often do you have your **teeth cleaned**? Every _____ months.

Health Information

- What drugs and medication are you taking at this time?
- What drugs have you stopped taking in the last six months?
- **Yes No** Are you now under the care of a physician? *If yes, please explain:*
- **Yes No** Have you been admitted to a hospital or needed emergency care?
  If yes, please explain:
- **Yes No** Do you have any health problems that need further clarification? *If yes, please explain:*
- **Yes No** Do you or have you ever smoked? *If yes, how many cigarettes per day for how many years?*
- **Yes No** Are you HIV Positive?

FOR WOMEN ONLY

- **Yes No** Are you pregnant or breast feeding? *If pregnant, what is the due date of birth*? _____/_____/_____
- **Yes No** Are you taking an oral contraceptive? (the "pill")

Name of Family Physician: _____ **Phone:** _____ **Date of last medical exam?** _____/_____/_____
Specialist _____**Phone:** _____

Have you ever had or been treated for any of the following? Please circle those that apply:

Abnormal Bleeding		
AIDS Related Complex	Head Injuries	Radiation Treatment
Alcohol or Drug Dependancy		Respiratory Problems
Allergies Reactions : **Aspirin Codeine Iodine** **Penicillin Latex** **Others**_____	**Heart** : Disease _____ - History of Coronary - Murmur - Surgery or Bypass - Mitral Valve Prolapse - Heart Valve Replacement	Rheumatic Fever Rheumatism Sinus Problems Special Diet Stomach Problems Stroke
Anemia/Blood Disorder	Hepatitis **A B C** Carrier?_____	Thyroid Disease
Arthritis	Jaundice	Tuberculosis
Artificial Joints (Bone, pins, plates)	Kidney Disease	Tumour (growth)
Asthma	Leukemia	Ulcers
Blood Pressure: Controlled/ High/ Low	Liver Disease	Venereal or other infection
Cancer	Lung Problems	**Other Medical or Comments:**
Diabetes	Malignant Hyperthermia	
Dizziness	Mental Disorders	
Epilepsy	Nervous Disorders	
Fainting Tendencies	Osteoporosis	
Glaucoma	Pacemaker	

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

As a condition of your treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and to communicate with other treating health-care providers, including other dentists, physicians, pharmacists and lab technicians.

I am aware of this office's privacy policy as posted in the reception area.
I have read the above conditions of treatment and agree to their content.

Dated at Ottawa this _____ day of _____/ _____ _____
Signature of patient, parent or guardian

Dated at Ottawa this _____ day of _____/ _____ _____
Signature of provider