Date: ____

PATIENT INFORMATION, HEALTH HISTORY AND CONSENT

All information is considered confidential and enables us to provide you with the best possible dental care.
By providing us with telephone numbers & email, you give us consent to contact, email or message you.

____

NAME: Last First Middle Initial

Date of Birth: ____________________________________ □ **Male** □ **Female**

Address: _________________________________ **City:** ________________ **Prov.** ____

Postal Code: ___________________ **Email:** ___________________________________

____

Tel. #: Home Cell Work + Extension

Occupation: ________________________ Pharmacy: _____________________________
(Location and telephone)

Physician: _______________________________ Tel.: _____________________________

How did you find out about this office: ____

EMERGENCY CONTACT or PARENT / GUARDIAN Relationship: ____________________

____

NAME: Last First Middle Initial

____

Tel. #: Home Cell Work + Extension

BENEFIT INFORMATION

Name of Insured: __________________________________ DOB: ____________________

Employer: __________________________ Insurance Carrier: ______________________

Plan/Policy: ______________________ Certificate/ID: ______________________________

□ Secondary Plan

Name of Insured: __________________________________ DOB: ____________________

Employer: __________________________ Insurance Carrier: ______________________

Plan/Policy: ______________________ Certificate/ID: ______________________________

EDI I authorize release of information contained in claims submitted electronically to my benefit company administrator

OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 HOURS NOTICE, failure to extend this courtesy may result in a fee to charge for the lost time.

Office policy is that services are paid for at each visit as they are performed. I am aware Northland Dental Centre is NOT responsible for what is paid or not paid for by my benefit plan. I have been informed that my file may be audited and that the team members of Northland Dental Centre may access this information. The office complies with the principles of PIPEDA (Privacy Act).

Date: ___________________________ Signature: ___________________________

If parent or legal guardian is signing:

Name: ____________________________ Signature: ______________________

Relationship: _______________________

MEDICAL HISTORY

Do you have any **implants / artificial joints or transplants** YES NO

____

Have you ever been told to take antibiotics prior to dental treatment YES NO

Have you ever been hospitalized YES NO reason:

____

Have you ever had radiation or chemotherapy YES NO

Have you ever had a severe blow / trauma to your face / head YES NO

Do you experience neck and/or back pain YES NO

Have you ever been involved in a motor vehicle accident (whiplash) YES NO

List ALL current medical problems:

____

____

List ALL SURGERIES and dates:

____

____

List any other MAJOR ILLNESSES and/or other injuries:

____

____

MEDICATIONS

List your current medications. Include any birth control pills, over the counter, herbal medications and/or recreational drugs)

____

____

Have you taken any prolonged medication in the past? ______________________________

____

ALLERGIES Do you have a latex allergy YES NO

(List any medication and/or food allergy(ies) and reactions:

____

____

Women are you pregnant? YES NO Due date: _______________ Breastfeeding? YES NO

FAMILY HISTORY

Please circle any medical problems that run in your family (grandparents, parents, siblings and/or children):

Arthritis	Asthma	Birth defects	Bleeding problems	
Diabetes (type) ________		Hay Fever	Thyroid disease	
Hearing loss	Hearth disease/heart attacks		Migraines	Hay fever
Kidney disease	Immune disorder		Hypertension	Tuberculosis
Seizures	Strokes / TIA's		Problems with anaesthesia	

Cancer (type) ____________________ Other _________________________________

SOCIAL HISTORY

Do you now or have ever used **tobacco** in any form? YES NO if yes:

what? __________ Amount? ________ How often? __________ Last time used _________

Soda YES NO how many ____________ Chew **gum** YES NO how often __________

Tea / Coffee YES NO how many ___________ with sugar? how many _____________

Alcohol YES NO how often ____________ **Thumb sucking**? YES NO how long __________

Are you currently having problems with any of the following? (circle **Y**es or **N**o as appropriately)

Night sweats	**Y**	**N**	Indigestion / pain with eating	**Y**	**N**
Recurrent fevers	**Y**	**N**	Chronic nausea / vomiting	**Y**	**N**
Gained or lost excessive weight	**Y**	**N**	Liver disease / jaundice	**Y**	**N**
Was the weight loss intentional	**Y**	**N**	Hepatitis (type) _____________	**Y**	**N**
Asthma	**Y**	**N**	Ulcers / gastritis	**Y**	**N**
Arthritis	**Y**	**N**	Acid reflux (heartburn)	**Y**	**N**
Emphysema	**Y**	**N**	Psychiatric treatment	**Y**	**N**
Hay Fever	**Y**	**N**	Cancer ________________	**Y**	**N**
Depression	**Y**	**N**	Kidney problems	**Y**	**N**
Eyeglasses / Contacts	**Y**	**N**	Fainting spells	**Y**	**N**
Glaucoma	**Y**	**N**	Seizures	**Y**	**N**
Eye disease ______________	**Y**	**N**	Speech difficulties	**Y**	**N**
Sinus problems	**Y**	**N**	Frequent headaches / migraines	**Y**	**N**
Ear infections / Earaches / Tubes	**Y**	**N**	Epilepsy	**Y**	**N**
Heart disease / angina	**Y**	**N**	Diabetes (type) _____________	**Y**	**N**
High blood pressure	**Y**	**N**	Thyroid disease	**Y**	**N**
Low blood pressure	**Y**	**N**	Hormone problems	**Y**	**N**
Heart murmur	**Y**	**N**	Rheumatic fever	**Y**	**N**
Heart attack	**Y**	**N**	Scarlet fever	**Y**	**N**
Stroke	**Y**	**N**	Tuberculosis	**Y**	**N**
Heart Pacemaker	**Y**	**N**	Drug / Alcohol dependency	**Y**	**N**
Anemia	**Y**	**N**	Immunologic disorders / deficiency	**Y**	**N**
Hemophilia	**Y**	**N**	AIDS / HIV	**Y**	**N**
Blood disorders ____________	**Y**	**N**	Herpes	**Y**	**N**
Bruise easily	**Y**	**N**	Venereal Disease	**Y**	**N**

Other (s) ____

DENTAL HISTORY

Previous Dentist __________________________ Last dental visit? _____________________

Any discomfort at this time? ____

Are your tonsils & adenoids present? **YES** **NO**

Have your wisdom teeth been extracted? **YES** **NO** when ____________________________

Have you ever been given local anesthetic (freezing)? **YES** **NO**

Have you ever been given general anesthetic? **YES** **NO**

Have you ever had a reaction, problems with anesthetic **YES** **NO**

Are you satisfied with the appearance of your teeth? **YES** **NO** ________________________

if no explain ____

Do you currently experience any of the following:

□ Clench and/or grind your teeth	□ Snore at night	□ Sleep Apnea
□ Bad Breath	□ Tender / Bleeding gums	□ Gagging
□ Loose Teeth	□ Popping or clicking in your jaw	□ Sensitive Teeth
□ Mouth breathing	□ Missing Teeth	□ Crooked Teeth

Do you have full or partial dentures? **YES** **NO** Are you satisfied with your dentures: **YES** **NO**

Consent for treatment **Initial** __________________

I consent to the performing of the dental procedures agreed to be necessary or advisable (including the use of general anesthetic as indicated) and I will assume responsibility for the fees associated with those procedures.

I certify that I have read, understood and accurately completed this form to the best of my knowledge and have not knowingly omitted any information. I consent to my current and previous dentist & physician(s) and other health care providers being contacted regarding my current and past conditions / medications.

Date: ____________________________ Signature: ____________________________

If parent or legal guardian is signing:

Name: ______________________________ Signature: ________________________

Relationship: ________________________ ***Reviewed by:*** _______________ (DDS / DH / CDAII)