



PATIENT WELCOME FORM

Our mission is to cultivate long-term patient relationships through a high standard of individualized care by incorporating cutting-edge technology with an honest and compassionate dental team

The information on this form is important for our records and your health. This information is strictly confidential. Thank you for your cooperation. We look forward to caring for your dental needs.

PERSONAL INFORMATION

PATIENT'S LAST NAME		FIRST	MIDDLE INITIAL	DATE OF BIRTH		SEX
PREFERRED NAME			HOME PHONE #		CELL PHONE #	
PATIENT'S ADDRESS		CITY	PROV.	POSTAL CODE	E-MAIL	
MARITAL STATUS		PATIENT/GUARDIAN'S EMPLOYER			OCCUPATION	
WORK ADDRESS		CITY	PROV.	POSTAL CODE	WORK PHONE #	
SPOUSE'S LAST NAME		FIRST	MIDDLE INITIAL	SPOUSE'S EMPLOYER		OCCUPATION
SPOUSE'S WORK ADDRESS		CITY	PROV.	POSTAL CODE	WORK PHONE #	
OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE						
WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?						
WHY DID YOU CHOOSE OUR PRACTICE?						

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME		RELATIONSHIP		
HOME PHONE #		WORK PHONE #		CELL PHONE #

REQUEST FOR CONFIDENTIAL COMMUNICATION

WHAT IS THE PRIMARY NUMBER WHERE WE CAN CONTACT YOU? HOME WORK CELL

WHAT IS YOUR PREFERENCE FOR OUR OFFICE TO CONFIRM YOUR APPOINTMENTS?

E-MAIL
TEXT
PHONE

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE YES NO		INSURANCE COMPANY NAME		INSURANCE PHONE #	
SUBSCRIBER NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT		SUBSCRIBER BIRTHDAY	
DIVISION #		GROUP/POLICY NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)	
SECONDARY COVERAGE YES NO		INSURANCE COMPANY NAME		INSURANCE PHONE #	
SUBSCRIBER NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT		SUBSCRIBER BIRTHDAY	
DIVISION #		GROUP/POLICY NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)	



RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTH CARE WITH

	<u>YES</u>	<u>NO</u>
HEALTH CARE PROVIDERS		
INSURANCE COMPANIES		
OTHERS (SPOUSE, PARENTS, ETC.)	_____	_____

ASSIGNMENT AND RELEASE

Dental insurance is designed to help aid in attaining optimum dental health; it is not designed to be a 'pay-all'. It is in your best interest to be sure that we have all of your current insurance information on file. We will do our best to answer any questions you have and are happy to process your claim forms at no charge.

We schedule your appointments to your convenience, and your punctuality is appreciated. If you need to reschedule your appointment, please provide us with two working days notice, in which case no cancellation fee will be applied.

I understand that I am responsible for payment of services rendered and that payment is due in full at the time of treatment unless prior arrangements have been agreed upon. I hereby authorize release of any information, either in print or electronic media, including the diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE PATIENT/GUARDIAN

DATE

WITNESS SIGNATURE

DATE



DENTAL HISTORY

Referred by _____
 Previous Dentist _____ How long have you been a patient? _____
 Date of most recent dental exam _____ Date of most recent x-rays _____
 Date of most recent treatment (other than periodontal therapy) _____
 I routinely see my dentist every: 3 Months 4 Months 6 Months 12 Months Not Routinely
 How would you rate the condition of your mouth? Excellent Good Fair Poor
 How often do you brush your teeth? Twice a Day Once a Day Once Every Few Days Not Routinely
 How often do you floss your teeth? Twice a Day Once a Day Once Every Few Days Not Routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

- Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)? [].....
- Have you had an unfavourable dental experience?.....
- Have you ever had complications from past dental treatment?.....
- Have you ever had trouble getting numb or had any reactions to local anesthetic?.....
- Did you ever have braces, orthodontic treatment or have your bite adjusted?.....
- Have you had any teeth removed?.....

BITE AND JAW JOINT

- Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping, etc.).....
- Do you / would you have any problems chewing gum, bagels, baguettes, protein bars or other hard foods?.....
- Have your teeth changed in the last 5 years, becoming shorter, thinner or worn?.....
- Are your teeth crowding or developing spaces?.....
- Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?.....
- Do you clench your teeth in the daytime?.....
- Do you have any problems with sleep or wake up with an awareness of your teeth?.....
- Do you wear or have you ever worn a bite appliance?.....

TOOTH STRUCTURE

- Have you had any cavities within the past three years?.....
- Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?.....
- Are any teeth sensitive to hot, cold, biting, sweets or do you avoid brushing any part of your mouth?.....
- Do you have grooves or notches on your teeth near the gum line?.....
- Have you ever broken teeth, chipped teeth, or had a toothache?.....
- Do you get food caught between any teeth?.....

GUM AND BONE

- Do your gums bleed when brushing or flossing?.....
- Have you ever been treated for gum disease or been told you have lost bone around your teeth?.....
- Have you ever noticed an unpleasant taste or odour in your mouth?.....
- Is there anyone with a history of periodontal disease in your family?.....
- Have you ever experienced gum recession?.....
- Have you ever had any teeth become loose on their own, or do you have difficulty eating an apple?.....
- Have you experienced a burning sensation in your mouth?.....

SMILE EVALUATION

- Do you like the way your teeth look? Yes No
Explain: _____
- Are you happy with the colour of your teeth? Yes No
Explain: _____
- Would you like your teeth to be whiter? Yes No
Explain: _____
- Would you like your teeth to be straighter? Yes No
Explain: _____
- Do you have spaces between your teeth that you would like closed? Yes No
If so, where? _____
- Would you like your teeth to be longer? Yes No
Explain: _____
- Do you like the shape of your teeth? Yes No
Explain: _____
- Do you have missing teeth that you would like to replace? Yes No
Explain: _____
- Do you have old silver fillings that you would like to replace with tooth-coloured fillings? Yes No
Explain: _____
- If you could change anything about your smile, what would you change?



MEDICAL HISTORY

Name of Physician and their specialty _____

Most recent physical examination _____ Purpose _____ Height _____ Weight _____

How would you rate your general health? Excellent Good Fair Poor

<u>DO YOU HAVE or HAVE YOU EVER HAD:</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
1. hospitalization for illness or injury.....	.	.	25. digestive disorders (ie gastric reflux).....	.
2. an allergic reaction to			26. osteoporosis/osteopenia (ie on bisphosphonates).....	.
aspirin, ibuprofen, acetaminophen, codeine,...	.	.	27. arthritis.....	.
penicillin, amoxicillin.....	.	.	28. glaucoma.....	.
erythromycin.....	.	.	29. contact lenses.....	.
tetracycline.....	.	.	30. head or neck injuries.....	.
sulpha.....	.	.	31. epilepsy, convulsion (seizures).....	.
local anesthetic.....	.	.	32. neurologic problems.....	.
fluoride.....	.	.	33. viral infections and cold sores.....	.
metals (nickel, gold, silver, _____).....	.	.	34. any lumps or swelling in the mouth.....	.
latex.....	.	.	35. hives, skin rash, hay fever.....	.
other.....	.	.	36. venereal disease.....	.
3. heart problems or cardiac stent in the last 6 months..	.	.	37. hepatitis (type _____).....	.
4. history of infective endocarditis.....	.	.	38. HIV/AIDS.....	.
5. artificial heart valve, repaired heart defect (PFO).....	.	.	39. tumour, abnormal growth.....	.
6. pacemaker or implantable defibrillator.....	.	.	40. radiation therapy.....	.
7. artificial prosthesis (heart valve or joints).....	.	.	41. chemotherapy.....	.
8. rheumatic or scarlet fever.....	.	.	42. emotional problems.....	.
9. high or low blood pressure.....	.	.	43. psychiatric treatment.....	.
10. a stroke (taking blood thinner).....	.	.	44. antidepressant medication.....	.
11. anemia or other blood disorder.....	.	.	45. alcohol/drug dependency.....	.
12. prolonged bleeding due to a slight cut (INR>3.5).....	.	.	<u>ARE YOU:</u>	
13. emphysema, sarcoidosis.....	.	.	46. presently being treated for any other illness.....	.
14. tuberculosis.....	.	.	47. aware of a change in your general health.....	.
15. asthma.....	.	.	48. taking weight management meds (ie fen-phen).....	.
16. breathing or sleep problems (ie snoring, sinus).....	.	.	49. taking dietary supplements.....	.
17. kidney disease.....	.	.	50. often exhausted or fatigued.....	.
18. liver disease.....	.	.	51. subject to frequent headaches.....	.
19. jaundice.....	.	.	52. a smoker or smoked previously.....	.
20. thyroid, parathyroid disease, or calcium deficiency..	.	.	53. considered a touchy person.....	.
21. hormone deficiency.....	.	.	54. often unhappy or depressed.....	.
22. high cholesterol or taking statin drugs.....	.	.	55. FEMALE – taking birth control pills.....	.
23. diabetes (HbA1c= _____).....	.	.	56. FEMALE – pregnant.....	.
24. stomach or duodenal ulcer.....	.	.	57. MALE – prostate disorders.....	.

Describe any current medical treatment, impending surgery or other treatment

List all medications, supplements, and or vitamins taken within the last two years

<u>Drug</u>	<u>Purpose</u>	<u>Dosage</u>	<u>Date First Prescribed</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 5 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____



PHOTOGRAPHY CONSENT FORM / RELEASE

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(Date)

(Signature of Adult Subject)

(Address)

(City, Province, Postal Code)

(Date)

(Signature of Parent or Guardian)

(Address)

(City, Province, Postal Code)