Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

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Patient or Parent/Guardian's Employer Business Address City Prov. State Spouse or Parent/Guardian's Name Employer Work Phone Whom may we thank for referring you? Person to contact in case of emergency Responsible Party Name of Person Responsible for this Account Address Home Phone Email Cell Phone Driver's License# Birthdate Birthdate Financial Institution Employer Work Phone SS#SIN St bits person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Name of Insured SS#,SIN Date Employed Name of Employer City Prov. PC. Insurance Company Group# State/ Prov. PC. Insurance Address Group How much have you used? Name of Insured Birthdate SS#,SIN DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING: Relationship to Patient Birthdate SS#,SIN DO YOU HAVE ANY ADDITIONAL INSURANCE? Vers State/ Prov. PC. Date Employed Name of Insured Birthdate SS#,SIN DO YOU HAVE ANY ADDITIONAL INSURANCE? Vers SITE SITE SITE SITE SITE SITE SITE SITE							
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Whom may we thank for referring you? Person to contact in case of emergency Responsible Party Name of Person Responsible for this Account Address Home Phone Email Cell Phone Driver's License# Birthdate Employer Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Rayment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Relationship to Patient Birthdate SS#/SIN Date Employed Name of Insured Birthdate SS#/SIN Date Employed Name of Employer City Prov. PC Insurance Company Group# State/ Prov. PC How much is your deductible? How much have you used? Name of Insured Birthdate SS#/SIN Do YOU HAVE ANY ADDITIONAL INSURANCE? Ves No If YES, COMPLETE THE TOLLOWING: Relationship to Patient Date Employed Max. annual benefit Date Employed Name of Insured Relationship to Patient State/ Prov. PC How much have you used? Name of Insured Relationship to Patient Date Employed Name of Insured Relationship to Patient Date Employed Name of Insured SS#/SIN Date Employed Name of Employer Name of E	Business Address		City	State/ Prov	P. C		
Responsible Party Name of Person Responsible For this Account Address Home Phone Email Cell Phone Driver's License# Birthdate Employer Is this person currently a patient in our office? Yes No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy. Insurance Information Relationship to Patient Birthdate SS#/SIN Date Employed Name of Insured Union or Local# Work Phone State/ Zip/ Prov. Prov. Prov. Insurance Company Group# Policy/ID# State/ Zip/ Prov. Prov. Prov. Birthdate Source Address Group# State/ Zip/ Prov. Birthdate Source Address City Prov. Prov. Brown much is your deductible? How much have you used? Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, COMPLETE THE FOLLOWING: Name of Insured Relationship to Patient Birthdate SS#/SIN Date Employed Name of Insured Relationship to Patient Date Employer Max. annual benefit DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, COMPLETE THE FOLLOWING: Name of Insured Relationship to Patient Birthdate SS#/SIN Date Employed Name of Employer Union or Local# Work Phone State/ Zip/ Prov. Prov. Prov. Date Employed Work Prov. Prov.	Spouse or Parent/Guardian's Name	E	Employer	Work Phone			
Responsible Party Name of Person Responsible for this Account Address	Whom may we thank for referring you?			Halle Table To the Control of the Co			
Name of Person Responsible for this Account	Person to contact in case of emergency			Phone			
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Address	1			Relationship to Patient	-		
Email	(F) (F)						
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Employer				-			
Is this person currently a patient in our office? \[\text{Yes} \] \ No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment. \[\] Cash \text{Personal Check} \text{Credit Card} \text{VISA} \text{MasterCard} \text{I wish to discuss the office's payment policy.} \[\] \text{Insurance Information} \] \[\] Name of Insured \text{SS#/SIN} \text{Date Employed} \text{Vork Phone} \text{State} \text{Zip/} \q							
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Over Please

	Office Phone		Date of I	Last Exam	17
Yes		No	10. Are you wearing contact lenses?		Yes
. Are you under medical treatment now?	Ц	1	. Are you wearing contact tens . Are you allergic to or have you had	any partians to the following?	
Have you ever been hospitalized for any			Local Anesthetics (e.g. Novoc		
surgical operation or serious illness within t	he last 5 years?		Penicillin or any other Antibi		
If yes, please explain			Sulfa Drugs		
7 1/2 1/2 1/2 1/2 1/2 1/2 1/2 1/2 1/2 1/2			Barbiturates		
Are you taking any medication(s)			Sedatives		
including non-prescription medicine?			Iodine		
If yes, what medication(s) are you taking?			Aspirin		
			Any Metals (e.g. nickel, merc		
Have you ever taken Fen-Phen/Redux?			Latex Rubber		
Have you ever taken Fosamax, Boniva, Acton			Other (please list)		
medications containing bisphosphonates?	anitea	1	. Do you have a persistent cough a		_
Have you taken Viagra, Revatio, Cialis or L	evitra		associated with a known illness (I	asting more than 3 weeks)?	
in the last 24 hours?			. Women Only:		
Do you use tobacco?		H	a) Are you pregnant or think	you may be pregnant?	
Do you use controlled substances? Do you have or have you had any of the foll	owing?		b) Are you nursing?		
Do you have or have you had any of the foll	owing:		c) Are you taking oral contra	ceptives?	
Yes	No		Yes No		Yes
High Blood Pressure	Heart Disease			ns	
Heart Attack	Cardiac Pacemak	er	Easily W	nded	
Rheumatic Fever 🔲	Heart Murmur				
Swollen Ankles	Angina		📙 📙 Hay Feve	r / Allergies	
Fainting / Seizures	Frequently Tired.			sis	
Asthma	Anemia			ı Therapy	
Low Blood Pressure	Emphysema			a	
Epilepsy / Convulsions	Cancer			eight Loss	
Leukemia	Arthritis			ease	
Diabetes	Joint Replacement			uble	
Kidney Diseases	Hepatitis / Jaundi			ry Problems	Щ
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Thyroid Problem	Stomach Troubles	/ Ulcers	U U Other		
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