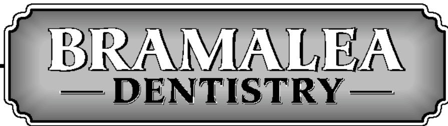


NEW PATIENT FORM

DATE MM DD YYYY

PERSONAL INFORMATION

Name LAST ____ FIRST ____ M ☐ F ☐ D.O.B. MM DD YYYY S.I.N. ☐☐☐ ☐☐☐ ☐☐☐
Address ____ City ____ Postal Code ☐☐☐ ☐☐☐
Phone HOME ____ WORK ____ CELL ____ E-mail ____
Occupation ____ Employer ____ Dental Insurance YES ☐ NO ☐
Person financially responsible for this account ____

Whom may we thank for referring you to our office? ____

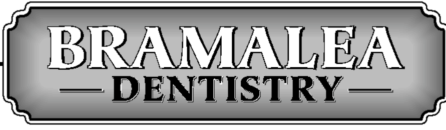
MEDICAL HISTORY

Physician LAST NAME ____ FIRST NAME ____ Phone ____

1. Are you now under the care of a physician for any problem? NO ☐ YES ☐
   If yes, please explain ____
2. Have you ever had a serious illness, operation, or been hospitalized? NO ☐ YES ☐
   If yes, please explain ____
3. Have you had a medical examination within the past year? NO ☐ YES ☐
   Any problems? ____
4. Are you now taking any medicines, pills, or drugs? NO ☐ YES ☐
   If yes, please explain ____
5. Do you have any allergies? NO ☐ YES ☐
   To what? ____
   Latex allergy? NO ☐ YES ☐
6. Are there any medicines, pills, or drugs you are not suppose to have? NO ☐ YES ☐
   If yes, please explain ____
7. Have you ever reacted adversely to any of the following?
   ☐ Penicillin ☐ Asprin ☐ Codiene ☐ Sedatives ☐ Barbiturates ☐ Sleeping Pills Other ____
8. Have you ever had local anaesthetic (freezing) in your mouth? NO ☐ YES ☐ Any ill-effects from it? ____
9. Have you ever had abnormal bleeding following extractions, surgery, or trauma? NO ☐ YES ☐
10. Are you pregnant? NO ☐ YES ☐ DUE-DATE MM DD YYYY
11. Do you have, or have you ever had, any of the following?

☐ Heart Trouble	☐ Heart Murmur	☐ Congenital Heart Lesions	☐ High Blood Pressure
☐ Sinus Trouble	☐ Stroke	☐ Epilepsy	☐ Low Blood Pressure
☐ Hepatitis A, B, C	☐ Kidney Disease	☐ Blood Transfusion	☐ Tuberculosis
☐ Ulcers	☐ Diabetes	☐ Sexually Transmitted Disease	☐ HIV infection
☐ Arthritis	☐ Cancer	☐ Psychiatric Treatment	

12. Is there anything in your medical history not yet mentioned? ____
13. Are you in good health? ____



DENTAL HISTORY

Previous Dentist ____LAST NAME____ ____FIRST NAME____ Phone ____________

1. When did you last see a dentist? ____________ 2. What was done for you?____________

3. What concerns you about your mouth today?____________

4. Are you pleased with your smile? YES ☐ NO ☐ What would you like improved?____________

5. Are you satisfied with the health of your mouth? YES ☐ NO ☐ What do you think is wrong? ____________

6. Do your gums bleed when touched with brush, floss, or other cleaning device? YES ☐ NO ☐

7. Which of the following do you use to clean your teeth?

☐ Toothbrush ☐ Electric Toothbrush ☐ Dental Floss ☐ Toothpick ☐ Rubber Tip Stimulator

☐ Toothpaste ☐ Mouthwash ☐ Water-pik ☐ Stimudent ☐ Tongue Cleaner

Other ____________

8. Are you missing any teeth? NO ☐ YES ☐

Do you want to replace any missing teeth? NO ☐ YES ☐ How? ____________

9. Do you clench or grind your teeth when awake or asleep? NO ☐ YES ☐

10. Do you have any discomfort at the jaw joint in front of your ear? NO ☐ YES ☐

11. The following habits can affect your oral health. Which apply to you?

☐ Chewing Gum (with sugar) ☐ Chewing Gum (sugarless) ☐ Frequent snacks between meals

☐ Smoking (cigarettes, cigar, pipe) ☐ Chewing Tobacco ☐ Bulemia (intentional vomiting)

☐ Carbonated Beverages (pop) between meals Other ____________

12. Have you ever had any of the following dental treatments?

☐ Orthodontics (braces to straighten teeth) ☐ Periodontal surgery for gums and bone support

☐ Root canal (nerve removed from tooth) ☐ Tooth knocked out was repositioned

☐ Crown (cap) ☐ Bridgework (false tooth attached to adjacent teeth)

☐ Removable denture ☐ Implant anchored in the bone to support false teeth

☐ Wisdom tooth extraction ☐ Bleaching to whiten teeth

☐ Bleaching in dental office ☐ Bleaching at home

☐ Cosmetic dentistry to improve the appearance of healthy teeth

13. To keep you comfortable during treatment, which may we use?

Local anaesthetic (freezing, Novocaine, Xylocaine etc.) YES ☐ NO ☐

Nitrous Oxide – Oxygen Conscious Sedation (laughing gas) YES ☐ NO ☐

DENTAL INSURANCE

Company Name ____________ Group number ____________

Employer ____________ Certificate number ____________

Name of policy holder ____________

OFFICE POLICY (please read)

1. Once you have made an appointment, this time is reserved for you. If you must change your appointment, we expect you to give us the opportunity to assign your time to someone else in need. 48 hours is desired. **No fee** is charged if your time is allotted to someone else. **$25 fee, or more, is charged for insufficient notice.**
2. Payments are made, or definite financial commitments are made, **at each visit** as services are performed.
3. Should **non-payment** occur, you may be subject to third party collection or legal action.
4. Regarding insurance: **Professional services are charged directly to the patient, and patients are personally responsible for payment.** We will provide any necessary forms or reports to help you collect your benefits from insurance companies. We may be able to submit claims electronically to your insurance company, but, the patient is ultimately responsible for payment.

PATIENT CONSENT

I understand that Bramalea Dentistry has a Privacy Code that can be reviewed at any time. I agree that Bramalea Dentistry can collect, use and disclose my personal information as set out in the office's privacy policies.

Signature ________________________ Date ________________ Witness ________________________

I agree to abide by the office policy. The information I have provided is correct and complete, to the best of my knowledge.

Patient's signature ____________________________ Dentist's signature ____________________________

Please visit ***www.BramaleaDentistry.com*** for more information about all aspects of our practice.

Do you want to earn $20/hour as a dental patient?

Tell us you are available for treatment on short notice, and qualify for a credit at the rate of $20/hr as a participant in our SNC programme. However, your SNC appointment may be cancelled on short notice if an emergency patient needs treatment. We try not to move regularly scheduled patients.