



NEW PATIENT FORM

DATE MM DD YY YY

PERSONAL INFORMATION

Name LAST FIRST M F D.O.B. MM DD YY YY YY S.I.N. 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 Aspirin 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 YY YY YY
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.