Welcome to our office !

Thank you for choosing us for your dental care. We appreciate the opportunity to serve you and strive to provide you with the highest quality dental care in a relaxed atmosphere. Our goal is to help you achieve and maintain excellent dental health. The better we communicate, the better we can care for your needs. If you have any questions, we will be delighted to help you.

Kindly fill out this form, as thoroughly as possible. Then fax, mail or bring it in with you to your next appointment. Our fax number is (416)922.6788 and our mail address is *94 Cumberland St., Suite 512 Toronto, ON M5R 3A6*. All information is confidential..

1. ABOUT YOU

Surname : ______________________ Address : ______________________

Name : ______________________ City : ______________________

I prefer to be called : ______________________ Postal code :______________________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Common-law ☐ Divorced ☐ Separated ☐ Widowed

Name of spouse / partner : ______________________

Home # : ______________ Work # ______________ Cell # ______________

Email address : ______________________ Date of birth ______________

Occupation : ______________ Employed by : ______________ How long :__________

2. GETTING TO KNOW YOU

Other family members / friends seen by us : ______________________

Whom may we thank for referring you ? ______________________

How did you hear about us ?

☐ Family / friend ☐ Yellow pages ☐ Internet / Web site ☐ Neighbour ☐ Other, please specify ______________

3. DENTAL INSURANCE

PRIMARY INSURANCE

Insurance co : ______________________

Policy holder : ______________________

Policy / Group # : ______________________

Certificate / ID # : ______________________

Date of birth of policy holder : ______________________

SECONDARY INSURANCE (*if applicable*)

Insurance co : ______________________

Policy holder : ______________________

Policy / Group # : ______________________

Certificate / ID # : ______________________

Date of birth of policy holder : ______________________

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Brown and staff to take x-rays, study models, photos and other diagnostic aids deemed appropriate by Dr. Brown to make a thorough diagnosis of my dental needs.
2. Upon such diagnosis, I authorize Dr. Brown to perform all recommended treatment mutually agreed upon.
3. I agree to the use of anaesthectis, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

OFFICE POLICY

1. We see all patients on an appointment basis so that we can provide the proper amount of time for each person. We endeavour to see all patients on time and ask that you extend the same courtesy to us. We consider an appointment made to be an agreement and commitment between our office and our patients. **If you are unable to keep an appointment, we require 2 business days' notice otherwise it will be necessary to charge for the time lost.**
2. I agree to be responsible for payment of all services rendered on my behalf or my dependants. **I understand that payment is due at time of service, unless other arrangements have been made.** In the event payments are not received by the agreed upon dates, I understand that a finance charge of 12% per annum will be added to my account.

Patient signature ______________________ Date ______________

4. DENTAL HISTORY

Are you experiencing any dental problems ? ____________________

Previous Dentist's name : ____________________ Date of last dental visit : ____________________

Date of last dental cleaning ____________________ Date of last full mouth x-rays ____________________

How often do you brush your teeth ? ____________________ How often do you floss? ____________________

What other dental aids do you use ? (electric, toothpick, etc.) ____________________

Are any of your teeth sensitive to :

Hot or cold ?	☐ Yes	☐ sometimes	☐ No
Sweets ?	☐ Yes	☐ sometimes	☐ No
Biting or chewing ?	☐ Yes	☐ sometimes	☐ No
Do your gums bleed or hurt ?	☐ Yes	☐ sometimes	☐ No
Do you get blisters, cold sores, any other oral lesions?	☐ Yes	☐ sometimes	☐ No
Are there any growths or sore spots in your mouth?	☐ Yes		☐ No

Have you ever had :

Orthodontic treatment (braces) ?	☐ Yes	☐ No
Root canal treatment ?	☐ Yes	☐ No
Periodontal (gum) treatment ?	☐ Yes	☐ No
Your teeth ground or the bite adjusted?	☐ Yes	☐ No
A bite plate or mouth guard ?	☐ Yes	☐ No
Teeth extracted due to abscess, accident, decay or gum disease - *underline one(s)* ?	☐ Yes	☐ No
Any problems after an extraction ?	☐ Yes	☐ No
A **serious** injury to the mouth or head ?	☐ Yes	☐ No

If so, please describe, including cause

____

Have you noticed :

Any mouth odours or bad tastes ?	☐ Yes	☐ No
Any loose teeth or change in your bite?	☐ Yes	☐ No
Does food tend to become caught between your teeth ?	☐ Yes	☐ No

If yes, where ____________________

Do you :

Bite your lips or cheeks regularly ?	☐ Yes	☐ No
Clench or grind your teeth ?	☐ Yes	☐ No
Breathe through your mouth ?	☐ Yes	☐ No
Have tired jaws, esp. in the morning?	☐ Yes	☐ No
Hold foreign objects with your teeth ? (pencils, pipe, pins, nails, fingernails)	☐ Yes	☐ No
Smoke / chew tobacco ?	☐ Yes	☐ No
Use street / recreational drugs ?	☐ Yes	☐ No

Have you experienced :

Clicking or popping of the jaw ?	☐ Yes	☐ No
Pain in your jaw joints, around ears, side of face ?	☐ Yes	☐ No
Difficulty in opening or closing the mouth?	☐ Yes	☐ No
Difficulty in chewing on either side of the mouth?	☐ Yes	☐ No
Pain when teeth are clenched ?	☐ Yes	☐ No

Are you satisfied with your teeth's appearance ? ☐ Yes ☐ No

If no, explain : ____________________

Do you feel nervous about having dental treatment? ☐ Yes ☐ No
If so, what is your biggest concern :

____

Have you ever had an upsetting dental experience? ☐ Yes ☐ No
If yes, please describe :

____

Is there anything else about having dental treatment that you would like us to know ? If yes, please describe :

____

5. MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years ? ☐ Yes ☐ No

Doctor's name ____________ Phone # ____________ Last physical ____________

2. Are you presently taking any medication, drugs or pills ? ☐ Yes ☐ No

   If yes, please list name and dosage : ____________

3. Are you allergic to or made sick by penicillin, aspirin, codeine, sulpha or any drugs or medication ? ☐ Yes ☐ No

4. Are you aware of having an allergic or adverse reaction to any substance ? ☐ Yes ☐ No

If yes, please list : ____________

5. Have you been a patient in the hospital during the past two years ? ☐ Yes ☐ No

6. Do you bleed **excessively** from a cut or injury ? ☐ Yes ☐ No

7. Circle any of the following which you have had or have at present:

AIDS	Chronic bronchitis	Heart (surgery, disease, attack)	Psychiatric/psychological care
Allergies or hives	Cold sores/ fever blisters	Heart murmur	Rheumatic fever
Anemia	Congenital heart disease	Heart pacemaker	Scarlet fever
Angina pectoris	Contact lenses	Hemophilia	Shortness of breath
Arthritis / Rheumatism	Cortisone medicine	Hepatitis A (infectious)	Sickle cell disease
Artificial heart valve	Diabetes	Hepatitis B (serum)	Sinus trouble
Artificial joints	Diet (special / restricted)	High blood pressure	STD
Asthma	Drug/alcohol addiction	HIV positive	Stroke
Blood transfusion	Epilepsy or seizures	Kidney trouble	Swelling (ankles, feet, hands)
Bruise easily	Emphysema	Liver disease	Thyroid problems
Bypass surgery	Fainting or dizzy spells	Mitrival valve prolapse	Tuberculosis
Cancer	Glaucoma	Nervousness / anxiousness	Tumours
Chemotherapy / radiation	Hayfever	Neurological disorders	Ulcers
Chest pain	Herpes (of any type)	Pain in jaw joints	Yellow jaundice

Additional information / Other condition not listed, : ____________

8. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs ? ☐ Yes ☐ No

9. Has your weight, energy level or appetite changed drastically recently ? ☐ Yes ☐ No

10. Is there a history of diabetes in the family ? ☐ Yes ☐ No

11. Do you get FREQUENT, SEVERE headaches, earaches, ear/throat infections ? ☐ Yes ☐ No

12. Have you ever had a general anaesthetic (been put to sleep)? ☐ Yes ☐ No

13. Have you had a local anaesthetic (novocaine) ? ☐ Yes ☐ No

14. Have you experienced any problems or complications with any type of anaesthetic? ☐ Yes ☐ No

15. WOMEN ONLY. Are you :
    Pregnant/anticipate becoming pregnant? ☐ Yes ___ *months* ☐ No **On birth control?** ☐ Yes ☐ No ____________

16. Has the **CHILD patient RECENTLY** had any of the following ?

☐ Chicken pox ☐ Measles ☐ Mumps ☐ Scarlet fever ☐ Strep throat ☐ Tonsillitis

I understand the above information it necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the Doctor of any change in my health or medication.

____________ ____________
Signature of patient / guardian Date

History review

Dentist signature ____________ Date ____________