BLOOR WEST DENTISTRY

Welcome to Bloor West Dentistry! To help us meet all of your dental needs, please fill out this form completely. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient Information

Dr. Mr. Mrs. Miss Ms Name: _____

Preferred Name: _____ Date of Birth (DD/MM/YYYY):_____

Home Phone: _____Work Phone: _____ Ext: _____

Cell Phone:_____Email:_____

Address: _____

City: _____Postal Code:_____

Occupation: _____Employer:_____

How did you hear about us?_____

Family Physician: _____ Physician's Phone:_____

Emergency Contact

Name: _____ Relationship: _____Phone:_____

Primary Insurance Information

Name of Insured :_____

Insurance Company: _____Birth date of Insured DD/MM/YYYY):_____

Division if applicable: _____Policy/Group:_____

Employer: _____ _____Certificate ID #:_____

Secondary Insurance Information

Name of Insured:_____

Insurance Company: _____Birth date of Insured (DD/MM/YYYY):_____

Division if applicable: _____Policy/Group:_____

Employer: _____ _____Certificate ID #:_____

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MEDICAL HISTORY	YES	NO
Are you being treated for any medical condition at present or within the last year?	❍	❍
If yes, specify:_____	❍	❍
When was your last medical check-up?_____		
Has there been any change in your general health in the past year? _____	❍	❍
Are you taking any medications or non-prescription drugs of any kind? Please list:	❍	❍
Drug: _____ Reason: _____		
Drug: _____ Reason: _____		
Drug: _____ Reason: _____		
Do you have any allergies? _ Latex _ Other: _____	❍	❍
Have you had an unusual reaction to any drugs or medicines? _____	❍	❍
_ Penicillin _ Sulfonamide _ Aspirin _ Codeine _ Local Anesthetic _ Other: _____		
Have you ever taken cortisone or steroid medication? _____	❍	❍
Do you have or have you ever had any heart problems, chest pain, or stroke? _____	❍	❍
Do you have a pacemaker? _____ _____	❍	❍
Do you have or have you ever had a heart murmur, mitral valve prolapse? _____ ___	❍	❍
Have you ever had rheumatic fever?_____	❍	❍
Do you or have you ever had jaundice, hepatitis A,B,C or liver disease?_____	❍	❍
Do you have a bleeding problem or bruise easily?_____	❍	❍
Do you have any conditions that could affect your immune system eg. AIDS, HIV infection, Leukemia etc?	❍	❍
Do you smoke? If yes, how many per day? _____	❍	❍
Have you ever been hospitalized for any serious illnesses or operation?_____	❍	❍
Do you have any prosthetic or artificial joints? _____	❍	❍

Do you have or have you ever had any of the following? (Please circle the conditions)

_ Chest Pain/Angina	_ Heart Attack	_ Low/High Blood Pressure	_ Stroke
_ Tuberculosis	_ Arthritis	_ Emphysema	_ Epilepsy
_ Thyroid Problems	_ Diabetes	_ Asthma	_ Stomach Ulcers
_ Kidney Disease	_ Cancer	_ Chemotherapy/Radiation	_ Psychiatric Disorder
_ Drug/Alcohol Dependency	_ Chronic Bronchitis	_ Osteoporosis	_ Dry Mouth

For females: Are you pregnant or breast feeding? _____	❍	❍
Any other conditions or problems of which the dentist should be aware of? _____	❍	❍

If yes, please list: _____

_____

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DENTAL HISTORY	**YES**	**NO**
-Have you been seeing a dentist regularly? _____	❍	❍
- Have you ever been advised to take antibiotics before dental appointments? _____	❍	❍
-Do your gums bleed when you brush? _____	❍	❍
-Do you feel that you have bad breath? _____	❍	❍
-Have you ever been in a motor vehicle accident or experienced any blows to your jaw? _____	❍	❍
-Have you ever had difficulty with local freezing?_____	❍	❍
-Are you satisfied with the appearance of your teeth?_____	❍	❍
-Have you ever had dental surgery? ❍ implant ❍ teeth extractions ❍ jaw ❍ gum	❍	❍

If yes, who performed the surgery?_____ when was it done? _____

Are you being followed-up by a dental specialist? _____

When was your last dental visit? _____When was your last dental x-rays?_____

Do you currently have sensitivity to: ❍hot ❍cold ❍sweet

(please mark if you have) ❍swollen gums ❍abcess

❍pain on chewing ❍loose/tipped teeth

Please list anything not mentioned above regarding your past dental history: _____

_____

General Release and Consent Statement

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. If required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided.

Consent for Collection, Use and Disclosure of Personal Information

I agree that Bloor West Dentistry has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy for Bloor West Dentistry and is in accordance with the *Personal Health Information Protection Act, 2004.*

_____ _____ _____

Signature Date (Print Name of Patient & Guardian/ Parent)

Reviewed by treating Provider _____ Date _____