Mr _ Dr_ Mrs_ Ms _
Preferred Name: _____ Date of Birth: _____(dd/mm/yy) _ Male _ Female
Address: _____
Apt/Unit#:_____
City: _____Province:_____Postal Code: _____Phone #:_____
Work #:_____ext. _____Cell #:_____
E-mail:_____
Employer: _____
Position: _____
Do you have any insurance benefits we can help you maximize? ☐ Yes ☐ No
Best way to contact you: _ Home Number _ Work Number _ E-mail _ Cell Number
☐ M ☐ T ☐ W ☐ T ☐ F __ am __pm
In case of an emergency – Please notify_____
Phone Number:_____
My Favourite: Travel Destination:_____Music:_____
Sport & Team:_____
Movie:_____Hobby:_____
How did you hear about us? (Check all that apply) Friend/Relative's name:_____
_ Flyer _ Radio _ Ad _ Internet - Keywords Typed:_____ Other_____
Mr Mrs Ms Miss Dr First Name:_____Last Name:_____

Please check any of the following problems that may apply to you.

___ Jaw joint pain (clicking/cracking) ___Teeth or fillings breaking _ Grinding or clenching teeth
_ Bleeding, swollen or irritated gums _ Loose, tipped or shifting teeth _ Bad breath or bad taste in your mouth
_ Loose/Poor fitting dentures _ Wears dentures _ Previous orthodontics or gum surgery
Sensitivity (hot, cold, sweet) Tooth pain or discomfort while chewing Headaches, earaches, neck pain

Please share the following dates:

Last dental cleaning _____ Last oral cancer screening _____
Last X-Rays_____

☐Yes ☐ No Have you ever smoked? If yes, how many years?_____ Do you currently smoke? ☐ Yes ☐ No
☐ Yes ☐ No Are you nervous during dental treatment?
☐ Yes ☐ No I would be interested in different sedation options to make my visits more relaxing?
☐ Yes ☐ No Do you wish to speak privately to the doctor about any problem or medical condition?

What, if anything, has kept you from having dental treatment?_____
_____
_____
What is the most important thing to you about your smile and dental health?_____
_____
_____
What is the most important thing to you about your first visit / today's visit?_____
_____
_____

Please check any of the following that apply to you:

☐ Rheumatic fever ☐ Anemia ☐ Excessive bleeding ☐ Arthritis ☐ Fainting
☐ Jaw joint pain ☐ Scarlet fever ☐ Glaucoma ☐ Artificial heart valve ☐ Kidney disease ☐ Seizures
☐ Artificial joints ☐ Heart conditions ☐ Blood disease ☐ Asthma ☐ Pregnant currently ☐ Heart murmur
☐ Snoring/Sleep apnea ☐ Pacemaker ☐ Stroke ☐ Bruise easily ☐ Heart surgery ☐ Thyroid disease
☐ Cancer ☐ Hepatitis A/B/C ☐ Tuberculosis ☐ Chemotherapy ☐ Diabetes ☐ Phen fen (1 month+)

☐ HI/LO blood pressure ☐ Mitral valve prolapse ☐ Venereal diseases ☐ Nervousness/Depression
☐ Liver disease/jaundice ☐ Radiation ☐ Heart lesions, congenital ☐ AIDS ☐ HIV positive
☐ Respiratory problems ☐ Allergies ☐ Emphysema ☐ Dizziness ☐ Drug Addiction
Other: _____

Do you have any of the following allergies?

_ Local anesthetic _ Penicillin _ Sulpha _Aspirin _Codeine _Darvon _Percodan _Latex

_ Yes _No Have you ever had a joint replacement?
If yes, when?_____
_ Yes _No Has your physician ever told you to take antibiotics prior to dental procedures?
If so, why? _____
_ Yes _No Have you ever-experienced complications following a medical or dental procedure?
If yes, please describe?_____
_ Yes _No Is there anything else you think we should know regarding your medical history?
If yes, please describe? _____
_ Yes _No Are you currently under a physician's care? If yes, what for?
_____
Yes _ No Are you taking any medications/supplements?
If yes, please specify_____
Name:_____ Reason:_____ Dosage: _____
Name:_____ Reason:_____ Dosage: _____
Name:_____ Reason: _____ Dosage: _____

Family Physician's Name:_____Physician's Phone Number:
_____

Medications

Privacy Information

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. 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 Village Dental Centre 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 at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

Signature: _____Date: _____

I the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Village Dental Centre all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____