

DUFFERIN & STEELES Dental Office

Last Name _____

Date of Birth: _____ / _____ / _____
Month Day Yr

Address: _____

Postal Code: _____

Email Address: _____

First Name _____

Nickname: _____

City: _____

Tel: _____

Work #: _____

Cell #: _____

Emergency Contact: _____

Relationship: _____

Family Doctor Name: _____

Previous Dentist: _____

Who referred you to our office? _____

Telephone: _____

Telephone: _____

Telephone: _____

Financial Information

Preferred Method of Payment: ☐ Cash/Debit ☐ Cheque ☐ MasterCard/Visa

Drivers License #: _____

Credit Card #: _____

Expiration Date: _____

Expiration Date: _____

Insurance Information: (if you have dual insurance, please present both cards to receptionist)

Name of insured: _____

Insurance company: _____

Employer name: _____

Date of Birth: _____

Policy/Group: _____

Certificate/ID#: _____

Secondary Insurance:

Name of insured: _____

Insurance company: _____

Employer name: _____

Date of Birth: _____

Policy/Group: _____

Certificate/ID#: _____

Authorization and Release

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE; THE ABOVE & FOLLOWING QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO MY CHILD OR MYSELF DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDANTS.

Privacy Act: Information

The enclosed information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality.

I have reviewed the information that explains how Dufferin Steeles Dental office will use my personal information, and the steps the office is taking to protect my information. I know that Dufferin Steeles Dental office has a Privacy code, and I can ask to see the code at any time. I AGREE that Dr. Ira Schechter and Dr. Michael Schechter, hygienists, and staff can collect, use and disclose personal information about myself as set out above in the information about the office's privacy policies.

Signature: _____

☐ Patient ☐ Parent/Guardian

Date: _____

Witness Signature: _____

Dental History

Reason for today visit: () Emergency () Exam () Other _____
How frequently did you see a dentist: () 3-6 months () Annually () Other _____
Date of last dental visit: _____ Last x-rays: _____
How often do you brush your teeth? _____
Floss: () YES, how often: _____ () NO, why _____
Type of toothpaste used _____
Do you use a water jet? _____ Mouth rinse? (name) _____
Is your drinking water fluoridated? _____ Do you use anti-bacterial rinse? (name) _____
Is there anything you would change about the appearance of your teeth? _____

Have you ever had an unpleasant dental experience? (if yes, please specify) _____

Please check appropriate boxes:

	YES	NO
Do your <u>gums bleed</u> while brushing/flossing? _____	()	()
Do you chew your lips/ tongue/ pencil /nails? (please circle) _____	()	()
Are your teeth sensitive to hot or cold liquids/food? _____	()	()
Are your teeth sensitive to sweets or sour liquids/foods? _____	()	()
Do you feel pain to any of your teeth? _____	()	()
Do you have any sores or lumps or swelling in or near your mouth? _____	()	()
Have you had any head, neck or jaw injuries- or major surgery? _____	()	()
Do you have frequent headaches? () YES Clench /Grind () YES		

Have you ever experienced any of the following problems in your jaw?

() Clicking () Pain (joint, ear side of face)
() Difficulty Opening/ Closing () Difficulty chewing

Do you notice any loosening of your teeth? _____	()	()
Do you have a bad taste in your mouth? _____	()	()
Does food tend to become caught between your teeth? _____	()	()
Have you ever had periodontal surgery? _____	()	()
Have you ever worn a bite plate or other dental appliance? _____	()	()
Do you wear dentures / partials? YES () If yes date of placement? _____		
Have you ever had any difficult extractions in the past? _____	()	()
Have you ever had any prolonged bleeding following extractions? _____	()	()
Have you ever received oral hygiene instructions regarding the care of your teeth/gums? _____	()	()

Nutritional

	YES	NO
Are you on regular medication including supplements or vitamins? _____	()	()
Have you ever received nutritional counseling? _____	()	()
What guidelines do you use for nutrition: _____		
Have you had biocompatibility testing of dental materials? Date: _____	()	()

Are you seeing/or have you seen within the last year any of the following:

() Naturopath () Nutritionist () Chiropractor () Physiotherapist () Osteopath
() Homeopath () Other _____

How much sun do you get? _____

Circle appropriate answer: (leave blank if you do not understand the question)

YES NO Is your general health good?

YES NO Has there been a change in your health within the last year?

YES NO Have you been hospitalized or had a serious illness in the last three years?
If YES, why? _____
YES NO Are you currently being treated by a physician /specialist? If YES for what?

Date of last physical exam? _____

Please check if you have experienced:

- | | | |
|--|---|--|
| ☐ Chest Pain (Angina) | ☐ Dizziness | ☐ Sinus Problems |
| ☐ Ringing in ears | ☐ Dry Mouth | ☐ Joint Pain, stiffness |
| ☐ Shortness of breath | ☐ Headaches | ☐ Seizure |
| ☐ Recent weight Loss, fever, night sweats | ☐ Fainting Spells | ☐ Jaundice |
| ☐ Persistent Cough, coughing up blood | ☐ Blurred vision | ☐ Other _____ |
| ☐ Bleeding problems, bruising easily | ☐ Swollen Ankles | |
| ☐ Frequent vomiting, nausea | ☐ Excessive thirst | |
| ☐ Difficulty Swallowing | ☐ Frequent Urination | |
| ☐ Diarrhea, constipation, blood in stools | ☐ Difficulty urinating, blood in urine | |

Please check if you have or have you had:

- | | | |
|---|---|--|
| ☐ Heart Disease | ☐ HIV | ☐ Thyroid Adrenal Disease |
| ☐ Heart Attack, heart defects | ☐ Tumors Cancer | ☐ Anemia |
| ☐ Heart Murmurs | ☐ Arthritis Rheumatism | ☐ Eye Diseases |
| ☐ Stroke, hardening of arteries | ☐ Skin diseases | ☐ Other _____ |
| ☐ High /Low blood pressure | ☐ Rheumatic /Scarlet Fever | |
| ☐ Asthma, TB, emphysema, lung disease | ☐ Diabetes | |
| ☐ Hepatitis (a) (b)(c) other liver disease | ☐ Herpes | |
| ☐ Stomach problems, ulcers | ☐ Kidney, bladder disease | |
| ☐ Family history of diabetes, heart problems, tumors | | |

Do you have or have you had an adverse reaction / allergy to:

- | | | | |
|---------------------------------------|---|--------------------------------------|--|
| ☐ Aspirin | ☐ Penicillin | ☐ Antibiotic | ☐ Barbiturates (Sleeping pills) |
| ☐ Latex | ☐ Local Anesthetic | ☐ Codeine | ☐ Food allergy _____ |
| ☐ Sulfonamides | ☐ Metal | ☐ Other _____ | |

Do you have or have you had:

- | | | |
|--|--|---|
| ☐ Radiation Treatment | ☐ Blood transfusion | ☐ Artificial Joint |
| ☐ Chemotherapy | ☐ Pacemaker | ☐ Prosthetic heart valve |

Are you taking: (if yes, specify dosage/frequency?)

- | | |
|--|---|
| ☐ Recreational drugs? _____ | ☐ Tobacco? _____ |
| ☐ Drugs, medications, (including over the counter medicines, natural remedies)? | ☐ Alcohol? _____ |

Name/Medication Dosage/Strength	Dosage/Strength	Name/Medication

Women Only:

- | | | | |
|--------|--|--------|--------------------|
| YES NO | Are you or could you be pregnant? Due Date _____ | YES NO | Are you nursing? |
| YES NO | Are you taking the birth control pill? | YES NO | Reached menopause? |