Patient Information

Last Name: ________________ **First Name:** _________________ **Preferred Name:** __________ **Title** _____

Gender: Male ____ Female ____ **Family Status:** Married _____ Single _____ Child _____ Other _____

Birth Date: ___________________ **Health Card #:** ____

Phone #s: Home: _______________ Cell: ____________________ Work: _______________ Ext.______

Preferred method of communication: E-mail ______ Home: _______ Cell: _________ Best time to call: ________

Street Address: ______________________________ **City:** ___________________ **Postal Code:** __________________

Family Medical Doctor: ______________________________ **Address and Phone number:** ________________________

Previous Dentist: ______________________________ **Date of last examination:** ___________________________

Occupation: ___________________ **Employer:** ___________________

Primary Insurance Information

Insurance Company: ____________________________ **Insured Employer Name**: ________________________________

Patient's relationship to insured: ______ Self ______ Spouse ______ Child ______ Other

Name of insured: **Last:** _________________ **First**: _________________ **Middle:** _________________

Birth Date of insured: _________________ **Group/Policy #:** _________________ **ID#:** _________________

Street address: _______________________________ **City:** ___________________ **Postal Code:** ______________

_____ I have secondary insurance. (Please provide this information to the receptionist)

Please indicate why you chose to come to our office:

____ Friend/Recommendation/Referral (please specify so that we may thank them): ______________________________

____ My family comes here ____ It's a convenient location for me ____ Yellow Pages/Phone book ____ Sign

____ Internet (please specify site e.g. google, ratemd, our website): ____

Health Questionnaire

These facts have a direct bearing on your dental health and will be considered confidential.

Please list all prescription and non-prescription medications you are currently taking (use reverse for more space):

____

____

For the following questions, circle yes or no:

Are you generally in good health?	Yes	No
Has there been any change in your general health within the year?	Yes	No
Are you now under a physician's care? ________________________________	Yes	No
Have you ever had any serious illness or operation?_____________________	Yes	No
Have you been hospitalized within the past 5 years? ___________________	Yes	No

Cardiovascular system Please indicate if you have or have ever had any of the following (please circle)

Heart trouble	Heart attack	Stroke	Damaged heart valves
Arteriosclerosis	Angina Pectoris	High Cholesterol	Congenital heart disease
Chest Pains	High Blood Pressure	Low Blood Pressure	Rheumatic heart disease
Cardiac pacemaker	Heart palpitations	Bruise easily	Anemia / Sickle cell
Jaundice	Blood disorders	Hemophilia	Abnormal bleeding

Last blood pressure reading: __________________________ Date: _______________________________

Central Nervous system Please indicate if you have or have ever had any of the following (please circle)

Epilepsy or other seizures	Fainting Spells	Emotional disturbances
Depression	Schizophrenia	Bipolar disorder
Neurological / Mental Disorder	Head trauma	Concussion
Numbness/tingling sensations		

Respiratory system Please indicate if you have or have ever had any of the following (please circle)

Tuberculosis	Sinusitis or sinus trouble	Emphysema
Bronchitis	Asthma	Shortness of Breath

Gastrointestinal system Please indicate if you have or have ever had any of the following (please circle)

Kidney/Bladder Problems	Liver Disease	Stomach Ulcers
Irritable Bowel Syndrome	Crones/Colitis	Celiac

Endocrine system Please indicate if you have or have ever had any of the following (please circle)

Diabetes	Hypothyroidism	Hyperthyroidism

Skeletal system Please indicate if you have or have ever had any of the following (please circle)

Osteoarthritis Rheumatoid arthritis Bone Infection Temporomandibular Joint Dysfunction

History of broken bones Osteoporosis/Osteopenia Artificial Joints/Implants ______________________________

Neoplasms Please indicate if you have or have ever had any of the following (please circle)

Cancer/Tumor or malignancy ________________ Chemotherapy or Radiation therapy? __________________

Infectious or Communicable Disease Please indicate if you have or have ever had any of the following (please circle)

Sexually Transmitted Diseases HIV AIDS Hepatitis Rheumatic Fever

Immune System Please indicate if you have or have ever had any of the following (please circle)

Asthma Hay Fever Hives or skin rash Anaphylaxis Swelling around the mouth

Allergies Have you ever had an allergic or adverse reaction to any of the following? (please circle):

Local anesthetics	Antibiotics	Aspirin	Ibuprofen	Tylenol	Codeine
Other NSAIDS	Narcotics	Sulfa drugs	Food Sensitivities	Other ___________________	

Information to make your appointments better Please indicate if you have any of the following (please circle)

Trouble hearing	Trouble seeing	History of ears, nose & throat problems
Persistent Thirst	Severe headaches	Can't lie down all the way
Difficulty swallowing	Acid reflux	Recent change of appetite
Frequent vomiting	Extra pillows to sleep	Urinate more than 6 times per day
Headaches	Sinus troubles	Tendency to faint
Hard to freeze	Jaw stiffness	

Women Please indicate if any of the following applies to you (please circle):

Pregnant Nursing Birth Control Pills Hormonal Therapy Post-menopausal

Other: Is there anything else concerning your health that you think the dentist should know about?

____

____

Dental Questionnaire

Date of last dental examination? ________________ Previous Dentist: _____________________ City: ___________

Do you have any complaints about your teeth?	Yes	No	______________________________
Do you have any discomfort or pain in your mouth?	Yes	No	______________________________
Are you able to eat and chew foods satisfactorily?	Yes	No	
Do you have any problems with your jaw joints?	Yes	No	

Do you have any problems with your bite?	Yes	No	
Have you had problems with pervious dental treatment?	Yes	No	___________________________
Do your experience tooth sensitivity to cold or hot liquids?	Yes	No	
Are you satisfied with the appearance of your teeth?	Yes	No	
Are you happy with the color of your teeth?	Yes	No	
Are you interested in discussing bleaching options?	Yes	No	
Are you interested in discussing teeth-straightening options?	Yes	No	
Are you interested in discussing cosmetic dentistry options?	Yes	No	

Do you do any of the following? (please circle those that apply)

Drink Tea	Drink Coffee	Drink Alcohol	Recreational drugs
Grinding/clenching	Snoring	Thumb-sucking	Chew fingernails

Do you currently have or have you ever had in the past: (Please circle those that apply)

Facial pain	sleep apnea	Jaw Pain	Headaches
Bleeding gums	Sensitive teeth	Earaches	Neck Pain
Braces	Invisalign	Retainers	Mouth guard
Biteplane/Night guard	Dentures/Partials	Crowns/Bridges	Implants

For the following questions, please check the response that best describes your situation:

1. I usually go to the dentist every:

☐ 3-4 months ☐ 6-12 months ☐ a year or more between visits ☐ I only go when I'm in pain

2. I routinely use the following dental products:

Manual toothbrush:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never
Electric toothbrush:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never
Dental Floss:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never
Mouthwash:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never

3. I suffer from dental anxiety:

☐ Not at all ☐ Mild ☐ Moderate ☐ Severe

Which one of the following situations best describes your attitude toward treatment?

☐ I am willing to do whatever it takes to save a tooth.

☐ My decision to save a tooth relies heavily on what it costs and the time commitment required.

☐ My decision to save a tooth relies heavily on whether it's covered by insurance.

☐ I would rather have it extracted.

Any other concerns or anything else you'd like us to know?

____

Authorization and Consent Form

Initial

_____ To the best of my knowledge, all of the information given regarding my medical and dental history is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

_____ I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

_____ I hereby authorize and request the performance of dental services for myself or for: ________________________

_____ I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by her supervised staff for diagnostic purposes or dental treatment.

______ I authorize the dentist to release information to other healthcare practitioners and insurance carriers. If there is a specific person(s) whom you would not want notified, please indicate _____________________________________

_____ I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

_____ I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I am responsible for this remaining balance. If I did not receive a quote, it is my duty to request one. I also understand that occasionally the need may arise to modify treatment and it's fee. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

_____ I understand that the dentist and staff do not know the details of my insurance plan as it is protected under a confidentiality clause. It is my responsibility to understand that plan and what is covered and what is not.

Signature: _____________________________________ Date: _________________________

___ Patient ___ Parent/Guardian

Please provide the following information if you would like to be have us accept assignment on your behalf. We will collect insurance payment and charge your card the remaining. If you prefer, you can pay for all treatment up front and get reimbursed from your insurance company afterward.

Master Card: ____ exp ______________

Visa: ____ exp ______________

Signature of cardholder: ____ Date: ______________________

Relationship to Patient ____

Date:___________________________________

To: ____________________________________

Re: ____________________________________

DOB:___________________________________

To ensure the accuracy and completeness of our dental records, we are requesting any radiographs and dental treatment history of your patient____

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Below is our patient's consent to the release of these records.

I____do hereby authorize the release of my dental history to Bedford South Dentistry, 15 Peakview Way, Unit 300, Bedford, NS, B3M 0G2.