Patient Information

Last name: _____ **First name:** _____ **Preferred name:** _____ **Title:** _____

Gender: Male ☐ Female ☐ **Family status:** Married ☐ Single ☐ Other ☐

Birth date (DD/MM/YYYY): _____ **Health Card #:** _____

Home phone: _____ **Mobile phone:** _____ **Work phone:** _____ **Ext.** _____

Preferred method of contact: E-mail ☐ Home # ☐ Mobile # ☐ Work # ☐ Text msg ☐

E-mail address: _____
(This information is not shared, and is used for early appointment reminders and confirmations)

Address: _____ **City:** _____ **Postal code:** _____

Family medical doctor: _____ **Address and phone number:** _____

Previous dentist: _____ **Date of last medical exam:** _____

Occupation: _____ **Employer:** _____

Primary Insurance Information

Insurance company: _____ **Plan member:** _____

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

Name of insured: Last: _____ First: _____ Middle: _____

Birth date of insured: (DD/MM/YYYY) _____ **Group policy #:** _____ **ID#:** _____

Address: _____ **City:** _____ **Postal Code:** _____

_____ I have secondary insurance (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) _____

☐ Family comes here ☐ Convenient location ☐ Phone directory ☐ Signage

☐ Internet (please specify: e.g. Google, Rate MD, our website, Facebook) _____

Previous Records

I have had dental x-rays/records in the past year Yes No

I would like to have my previous dental records received by Bedford South Dentistry Yes No

Health Questionnaire

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

MEDICATIONS: List all prescription and non-prescription medications you are currently taking.

_____

_____

ALLERGIES: Have you ever had an allergic or adverse reaction too any of the following? (circle)

Local anesthetics	Antibiotics	Aspirin	Ibuprofen	Tylenol	Codeine
Other NSAIDS	Narcotics	Sulfa drugs	Food sensitivities	Other	_____

GENERAL HEALTH: For the following questions, circle yes or no:

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

If you have been hospitalized, can you provide a brief description why? _____

CARDIOVASCULAR SYSTEM: Please indicate if you have, or have ever had, any of the following: (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: (circle)

Epilepsy or other seizures	Numbness or tingling sensations	Head trauma	Bipolar disorder
Depression	Schizophrenia	Emotional disturbances	Concussion
Neurological or mental disorder			Fainting spells

RESPIRATORY SYSTEM: Please indicate if you have or have ever had any of the following: (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: (circle)

Kidney/bladder problems	Liver disease	Stomach ulcers
Irritable bowel syndrome	Crohn's or colitis	Celiac

ENDOCRINE SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Diabetes Hypothyroidism Hyperthyroidism

SKELETAL SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Osteoarthritis	Rheumatoid arthritis	Bone infection	Temporomandibular joint
Dysfunction	Osteoporosis	Artificial joints	_____
History of broken bones	Osteopenia	Implants	_____

NEOPLASMS: Please indicate if you have or have ever had any of the following:(circle)

Cancer, tumour or malignancy _____ Chemotherapy or radiation therapy _____

INFECTION OR COMMUNICABLE DISEASE: Please indicate if you have or have ever had any of the following: (circle)

Sexually-transmitted diseases	Creutzfeldt-Jakob disease	HIV	AIDS
Hepatitis	Rheumatic fever	Other Transmissible Spongiform Encephalopathy	

IMMUNE SYSTEM: Please indicate if you have any of the following: (circle)

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

INFORMATION TO MAKE YOUR APPOINTMENTS BETTER: Indicate if you have any of the following: (circle)

Trouble hearing	Trouble seeing	History of ear, nose, and 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: Indicate if any of the following applies to you: (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

Last dental examination: _____ Previous dentist: _____ City: _____

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 previous dental treatment?	Yes	☐	No	☐
Do you 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 colour 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? (circle)

Drink tea	Drink coffee	Drink alcohol	Recreational drugs	Smoke
Grinding/clenching	Snoring	Thumb-sucking	Chew fingernails	

Do you currently have or have you ever had in the past: (circle)

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 is covered by insurance.
☐ I would rather have it extracted.

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

Dentist's signature: _____

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 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) who should not be notified, please indicate _____.

_____I understand that I am financially responsible for ALL services and procedures, and that payment-in-full is expected on the day of my visit, after which Bedford South Dentistry will happily send my claim online so that I will be reimbursed quickly for the dental benefits in my plan.

_____I understand that the dentist and staff do not know the details of my dental benefits plan as it is protected under privacy regulations. It is my responsibility to understand my plan and what is covered and what is not.

_____If I did not receive a quote, it is my duty to request one. I understand that occasionally it may be necessary to modify a treatment and the fees associated with that treatment.

NOTE: Failure to contact us without 48 hours' notice is not considered formal cancellation and you may be charged a nominal $50 cancellation fee. This policy is essential for the efficient functioning of our dental practice.

Signature: _____

Print name: _____

Date: _____

___ Patient ___ Guardian

Relationship to patient _____

Bedford South Dentistry
love your smile
15 Peakview Way Unit 300, Bedford South, NS, B3M 0G2
4-DENTAL(433-6825) www.bedfordsouthdentistry.com

Patient Records Consent Form

Transfer of records from:

Previous dentist: _____

Address: _____

Fax number: _____

New dentist information:

New dentist: Dr. Natalie Brothers Dr. Jillian Reynolds Dr. Bonnie Theriault Dr. Allison Thibault

Address: Bedford South Dentistry
15 Peakview Way, Suite 300
Bedford, N.S. B3M 0G2
Phone: (902) 433-6825 Fax: (902) 835-3831

E-mail: reception@bedfordsouthdentistry.com

I hereby give authorization to release a copy of my dental records to the above-named dentist.

Patient name: _____

Patient address: _____

Patient phone: _____

Patient signature: _____

Date: _____