Patient Information – children ages 6 to 18

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

Gender: Male ☐ Female ☐ **Health card #:** _____

Birth date (DD/MM/YYYY): _____

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) _____

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
Other NSAIDS	Narcotics	Sulfa drugs	Food sensitivities	Other

Do you have an allergy or sensitivity to latex? Yes ☐ No ☐

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

INFECTIOUS 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	

INFORMATION TO MAKE YOUR APPOINTMENTS BETTER: Please 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	

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

_____

_____

_____

Dental Questionnaire

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. Is this your first dental visit? Yes ☐ No ☐

If not, when was your last visit to the dentist? _____

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

4. Are you happy with the colour of your teeth? Yes ☐ No ☐
5. Are you happy with your smile? Yes ☐ No ☐
6. If no, are you interested in discussing your options? Yes ☐ No ☐

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? _____

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 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 notify us.

_____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.

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: _____

DDS Signature: _____