DENTISTRY ON KINGSRIDGE

2015 Kingsridge Dr., Unit 5. Oakville, ON L6M 4Y7 I Tel: (905) 847-1848 I Fax: (416) 987-5597 I dentsonkings@mouthfxr.com

PATIENT INFORMATION

Demographics:
1. Name: _____
2. Date of Birth: (Day/Month/Year) _____/_____/_____
3. Address: _____
_____
Postal Code: _____
4. Phone (HOME) _____ (OFFICE) _____
5. S.I. N #: _____
6. Occupation: _____ 7. Email _____

Emergency Contact:
1. Name: _____
2. Relationship: _____
3. Daytime Phone: _____
4. Name of Family Dr.:_____
Phone: _____
5. Medical Specialist: _____
Area of Specialty:_____
Phone:_____

Primary Name: _____ Date of Birth: _____ Employer: _____
Dental Insurance: Yes ☐ No ☐
1 Insurance: _____ Group Policy. #: _____ Certif. #: _____
2 Insurance: _____ Group Policy. #: _____ Certif. #: _____

Person Responsible for Account: Self ☐ Other ☐

Name:_____
Address:_____
Phone (HOME) _____ (OFFICE) _____

Who may we thank for referring you to our office? _____

MEDICAL HISTORY:
The following 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.

1. Are you being treated for any medical condition at present or within the last year? Yes ☐ No ☐

_____

2. When was your last medical check-up? _____

3. Are you presently taking any medications? If yes, please list: Yes ☐ No ☐

_____

_____

4. Do you have any allergies to drugs, latex or foods? Yes ☐ No ☐

_____

5. Do you have or have you ever had any heart or blood pressure problems? Yes ☐ No ☐

6. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? Yes ☐ No ☐

7. Have you ever been advised by your doctor to take antibiotics before dental treatment? Yes ☐ No ☐

8. Do you have or have you ever had jaundice, hepatitis or liver disease? Yes ☐ No ☐

9. Do you have any condition that could affect your immune system (AIDS, HIV +, Leukemia)? Yes ☐ No ☐

10. Do you have a bruising problem or bleeding disorder? Yes☐ No☐

11. When walking, do you ever have to stop because of pain in your chest or shortness of breath? Yes☐ No☐

12. Have you ever been hospitalized for any serious illnesses or operations? Yes ☐ No☐
If yes, please explain

_____

13. Do you have or have you ever had any of the following? Please tick off only those that apply:

☐ chest pain, angina	☐ shortness of breath	☐ asthma	☐ cancer	☐seizure
☐ heart attack	☐ prosthetic heart valve	☐ emphysema	☐ diabetes	☐ thyroid
☐ stroke	☐ pacemaker	☐ bronchitis	☐ stomach ulcer	☐ kidney
☐ steroid therapy	☐ drug/alcohol dependency	☐ tuberculosis	☐ diet pill therapy	☐ arthritis

15. Are there any conditions or disease not listed above that you have or have had? If so what? Yes☐ No☐

_____

16. Are there any diseases or medical problems (e.g. diabetes) that run in your family Yes☐ No☐

17. Do you smoke or chew tobacco products? Yes☐ No☐

18. Are you nervous during dental treatment? Yes☐ No☐

19. For women only: Are you breast feeding or pregnant? If pregnant, what is your expected delivery date?

Yes☐ No☐

DENTAL HISTORY:

1. Name and address of your previous dentist _____

2. When was your dental visit? _____ Reason? _____

3. When did you last have dental x-rays? _____

4. Have you had any of the following? Tick off only those that apply.

☐ Periodontics (gum treatment)	☐ fillings	☐ dental implants	☐ full or partial dentures	☐extractions
☐ Regular cleanings	☐ caps, crowns or bridges	☐ root canal	☐ orthodontics (braces)	☐ jaw injury

5. How often do you brush your teeth? _____ How often do you floss your teeth? _____

6. Have you ever had a local anesthetic (e.g. dental freezing)? Yes No
If yes, did you have any problems? Describe _____

7. Would you like to improve the general cosmetic appearance of your teeth Yes No
If yes, what would you like to change? _____

8. Do you presently have or think you may have any of the following? Please check.

☐ Loose teeth	☐ A bad taste in your mouth	☐ Grinding teeth
☐ Cavities	☐ A clicking or sore jaw	☐ Clenching teeth
☐ Gum disease	☐ Earaches or headaches	☐ Teeth not white enough
☐ Sensitive teeth	☐ Unsightly or broken fillings	☐ Crooked teeth
☐ Bleeding gums	☐ Bad breath	☐ Malaligned teeth

9. In your own words, describe you present dental problems or needs:

_____

_____

Office Philosophy and policy (please read):

- In an effort to determine a treatment plan that is best for your overall dental health, we must make a careful diagnosis. This involves a thorough examination, often utilizing the minimum number of x-rays necessary for accuracy.
- We pledge to provide high quality dentistry in the most comfortable manner possible, with the best equipment, materials and up-to-date techniques. The long-term success of our effort will depend on the patient's willingness to maintain their teeth and help to prevent any future dental problems.
- Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we require 2 business days notice, or a cancellation fee may be charged. All urgent dental problems will be attended to the same day, under normal circumstances. You may call our office or answering service at any time.
- Our office policy is that services are paid for at each visit as they are performed. In certain circumstances, financial arrangements for payments may be made by consulting with the dentist or receptionist.
- Regarding Insurance: All patients with dental insurance are responsible for payment of their own accounts. We are pleased that you may have insurance to reimburse or minimize your personal expenditure and we will gladly complete any claim forms to assist you in collecting your dental benefits. Please make certain you understand any limitations in your contract. We will gladly submit "estimate" forms, if necessary.
- Regarding your privacy: Protecting your personal information is important to us. We are committed to collecting, using, and disclosing your personal information responsibly, and try to be as transparent as possible about the way we handle this information. Please be assured that only necessary information is collected about you. We only share your information with your consent, and storage, retention, and destruction of this information complies with existing government legislation and privacy protection protocols as set out by the Royal College of Dental Surgeons of Ontario. In this office, Dr Zaimin Dawood is the Privacy Information Officer. More details about our privacy policy is outlined in our Privacy Code, a copy of which you can view at any time by asking us for one.
- A healthy dentist-patient relationship is based on mutual respect and understanding. Please feel relaxed and open to discuss with us, any aspect of your treatment or fees, at any time.

Consent:
I confirm that the above medical and dental information is true and complete to my knowledge. I have read and fully understand the policy regarding the payment of fees and will assume responsibility of fees associated with dental procedures performed.

Signature: (Patient, parent, guardian)_____ Date: _____

Signature: Dentist_____ Date: _____

Dentist Notes: