New Patient Information
The Airport Dental Centre

Patient's Legal Name_____ Date of Birth_____

Mailing Address_____ SIN #_____

City/Prov/Postal_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer_____

May we call you at work? Yes No May we leave a message? Yes No

Whom may we thank for referring you?

Person financially responsible for the account_____ Driver's License # _____

Date of Birth_____ Email_____

I hereby authorize payment of the dental insurance benefits otherwise payable to me directly to The Airport Dental Centre. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize The Airport Dental Centre to release all information necessary to secure payment. It is my responsibility to pay any deductibles, co-payments and any other fees not paid by insurance.

Patient's Signature_____ Date_____

(If patient is a minor, a parent or guardian must sign.)

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Name of Dental Insurance_____ Insurance Year End_____

Yearly Insurance Coverage Maximum_____ % Cov for_____ Basic_____ Major Rest_____ Ortho_____

Name of Policy Holder_____ Group #_____ Member ID #_ _____

Date of Birth (Policy Holder)_____ SIN#_____

Employer Name_____ Employer Phone #_____ Ins. Company Phone #_____

Secondary Dental Insurance

Name of Dental Insurance_____ Insurance Year End_____

Yearly Insurance Coverage Maximum_____ % Cov for_____ Basic_____ Major Rest_____ Ortho_____

Name of Policy Holder_____ Group #_____ Member ID #_____

Date of Birth (Policy Holder)_____ Soc. Security # (Policy Holder) _____

Employer Name_____ Employer Phone #_____ Ins. Company Phone #_____

DENTAL HISTORY

What is the reason for todays visit?

When was your last visit?

When was your last Complete Dental Exam including charting?

Are your teeth Sensitive to cold/sweets/heat?

Do you grind or clench your teeth?

Do your gums bleed when you brush?

Have you ever had any complications with local anesthetic?

Any problems with previous dental treatment?

Are you satisfied with the look of your teeth?

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: MR./MISS/MRS./MS./DR.

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME):

PHONE:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

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. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:

☐ YES ☐ NO ☐ NOT SURE/MAYBE

a) medications
b) latex/rubber products
c) other e.g. hayfever, foods

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

7. Do you have or have you ever had asthma? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

11. Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

12. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

13. Have you ever had hepatitis, jaundice or liver disease? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

14. Do you have a bleeding problem or bleeding disorder? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

16. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ shortness of breath	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)	☐ drug/alcohol dependency
☐ heart attack		☐ lung disease	☐ diabetes	☐ kidney disease	
☐ stroke	☐ prosthetic heart valve	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	
		☐ cancer	☐ arthritis	☐ diet pill therapy	

17. Are there any conditions or diseases not listed above that you have or have had? If so, what? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

18. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ YES ☐ NO ☐ NOT SURE/MAYBE

19. Do you smoke or chew tobacco products? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

20. Are you nervous during dental treatment? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

21. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

DENTIST SIGNATURE: _____ **DATE:** _____

DENTIST'S NOTES