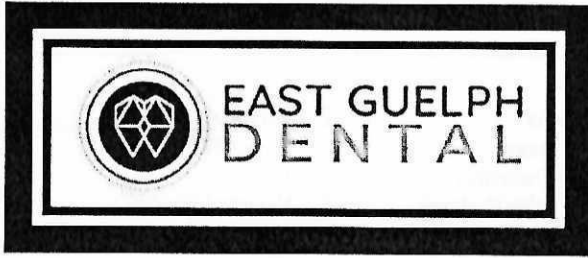


We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Personal Information

Surname________________ First________________ Date of Birth________ Gender: M☐ F☐

Address________________ City____________ Postal Code________

Occupation____________ Employer__________ Address________________

Phone (Res)____________ Phone (Bus)____________ Phone (Cell)____________

Email________________________

Family Physician____________________ Phone (Bus)____________

Date of Last Exam________ Marital Status:________ Health Card #____________

Name of Spouse, Parent, or Guardian________________________

Occupation____________ Employer__________ Address________________

Phone (Res)____________ Phone (Bus)____________

Emergency Contact____________ Relationship__________ Phone____________

Whom may we thank for referring you to our practice?

☐ Another Patient________________ ☐ Doctor________________

☐ Staff________________ ☐ Online/Social________________

☐ Advertisement ☐ Magazine ☐ TV ☐ Newspaper ☐ Radio ☐ Other____________

Insurance Information

Do you have dental insurance? Yes☐ No☐

Name of Insured____________________ Insured Date of Birth________

Insurance Company________________ Group #________ ID #____________

Driver's License #________________

This information is collected to verify identity and settle any account balances not covered by insurance.

Secondary Insurance Information

Do you have dental insurance? Yes☐ No☐

Name of Insured____________________ Insured Date of Birth________

Insurance Company________________ Group #________ ID #____________

Driver's License #________________

This information is collected to verify identity and settle any account balances not covered by insurance.

See other side.

Health Information

Do any of the following apply to you?

☐ AIDS/HIV	☐ Epilepsy/Convulsions	☐ Leukemia	☐ Surgery________
☐ Allergies	☐ Excessive Bleeding	☐ Liver Disease	☐ Thyroid Problem
☐ Anemia	☐ Fainting Seizures	☐ Mental Disorders	☐ Ulcers
☐ Angina	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Venereal Disease
☐ Arthritis	☐ Growths	☐ Nervous Disorder	☐ Other: ________
☐ Artificial Joints	☐ Hay Fever	☐ Pacemaker	
☐ Asthma	☐ Head Injuries	☐ Pregnancy Due________	☐ Complications after dental treatment
☐ Blood Disease	☐ Heart Attack	☐ Radiation Treatment	☐ Need for admission to a Hospital/Emergency
☐ Cancer	☐ Heart Murmur F/O	☐ Respiratory Problems	☐ Under the care of a physician
☐ Cannabis Use	☐ Heart Problems	☐ Rheumatic Fever	☐ Any health concerns
☐ Cigarette Smoking	☐ Hepatitis: A B C (circle)	☐ Rheumatism	________
☐ Codeine/Penicillin Allergy	☐ High Blood Pressure	☐ Sinus Problems	________
☐ Diabetes	☐ Jaundice	☐ Stomach Problems	
☐ Dizziness	☐ Kidney Disease	☐ Stroke	
☐ Emphysema	☐ Latex Allergy		

Dental Information

Please check those that apply:

☐ Bad Breath	☐ Extractions	☐ Local Anaesthetic Reaction	☐ Strong Gag Reflex
☐ Bad Experience	☐ Fillings	☐ Loose/Broken Teeth	☐ Sensitivity to Biting
☐ Bleeding Gums	☐ Fingernail Biting	☐ Mouth Breathing	☐ Sensitivity to Cold
☐ Blisters in Mouth	☐ Food Trapped in Teeth	☐ Mouth Pain	☐ Sensitivity to Hot
☐ Burning Sensation	☐ Foreign Objects	☐ Orthodontic Treatment	☐ Sensitivity to Sweets
☐ Chewing on One Side	☐ Grinding Teeth	☐ Pain Around Ear	☐ Sores/Growths in Mouth
☐ Clicking Jaw	☐ Gums Swollen/Bleeding	☐ Peridontal Treatment	☐ Syncope (Fainting)
☐ Crowns/Bridges	☐ Jaw Pain	☐ Removable Denture	
☐ Dry Mouth	☐ Lip/Cheek Biting	☐ Root Canal Therapy	☐ Any other conditions

Reason for todays visit:________________

Former Dentist:________ City:________ Prov:________

Date of last dental visit:________ Date of last dental x-rays:________

How often do you brush:________ Floss:________

Medication

List of medications you are currently taking:

________ ________ Pharmacy name:________

________ ________ City/Prov:________

________ ________ Phone:________

Authorization

I, the undersigned patient, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information.

I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated.

Unless other arrangements are made, payment is due at each office visit. My dental insurance is a contract between myself and the insurance company, not between the dentist and myself.

I will assume full responsibility for the fees associated with these procedures.

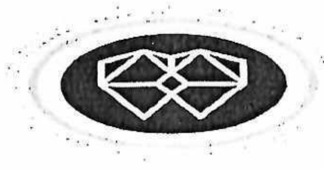
I am aware that 2-business days notice is required to change or cancel an appointment without charge.

I agree that Vansittart Dental can collect, use and disclose personal information about myself or my dependents as set out in the office's privacy policies, and consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. I further agree to receive electronic messages, including text messages, in regards to communicating appointments, requests, information, products, promotions, company news and updates which can be withdrawn at any time. I further consent to being videotaped in public areas of the dental office.

________ Patient/Guardian Signature

________ Dentist Signature

________ Date



DENTAL

490 Clair Rd. East

Guelph, Ontario

N1L 1C3

Dental Records Release Forms

Patient Name to Transfer: ________________________.

Date of Birth: _______________.

Phone Number: _______________ Cell Number: ______________.

Other Family Members to Transfer: ________________________.

Previous Dentist or Practise Name: ___________________________.

That office phone number______________________________.

Please forward any of the following information that you have:

Current (or last 3 years), Chart probing depths, Copy of charting and photographs to: East Guelph Dental.

Digital Records may be sent to:

Info@eastguelphdental.com

Patient signature (parent if a minor); ______________________________.

Date: ____________________.

Thank-you in advance for your co-operation.