

# NEW PATIENT INFORMATION FORM

Do you have a fever, difficulty breathing or a cough? YES  NO   
Have you returned from travel in the last 14 days? YES  NO   
Have you been in contact with a suspected or confirmed case of COVID-19? YES  NO   
Are you experiencing pain or discomfort? YES  NO

## PERSONAL INFORMATION

Today's Date: \_\_\_\_\_ Full Legal Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Tel. No. (Home): \_\_\_\_\_ Tel. No. (Work): \_\_\_\_\_  
Tel. No. (Cell): \_\_\_\_\_ Email Address: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Emergency Contact Tel. No. \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name of Primary Physician: \_\_\_\_\_ Telephone No. of Primary Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

## INSURANCE INFORMATION (IF APPLICABLE)

### Primary

Subscriber Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Policy Group Number: \_\_\_\_\_ Division: \_\_\_\_\_  
Certificate Number: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

### Secondary

Subscriber Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Policy Group Number: \_\_\_\_\_ Division: \_\_\_\_\_  
Certificate Number: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

## MEDICAL HISTORY AND DETAILS

Have you been hospitalized or had a major operation within the last 2 years? Yes  No   
If you indicated "Yes", please provide details: \_\_\_\_\_

Are you or could you be pregnant and/or breastfeeding? Yes  No   
If you indicated "Yes", please provide details: \_\_\_\_\_

Do you have, or have you ever had, a heart condition or tested positive for a disease that could affect your immune system? (e.g. leukemia requiring chemotherapy) Yes  No   
If you indicated "Yes", please provide details: \_\_\_\_\_

Please indicate which of the following you have had or have ever had:

AIDS/HIV Positive	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Head or Neck Injuries	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Alzheimer's Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Attack/Failure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anaphylaxis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Murmur	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Pacemaker	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Arthritis/Gout	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Heart Surgery	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Artificial Heart Valve	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Hemophilia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Artificial Joint	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Hepatitis A/B/or C	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Asthma	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>					
Blood Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	High Blood Pressure	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Bruise Easily	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Infective Endocarditis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cancer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Jaundice	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Chest Pains	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Alcohol or Drug Dependency	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Circulation Problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Liver Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Diabetes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Lung Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Emphysema	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Mental/Nervous Disorder	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Epilepsy/Seizures	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Organ/Medical Transplant	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Psychiatric Disorder	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Prosthetic Joints	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Eating Disorder	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Sickle Cell Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Fainting	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Stroke	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Glaucoma	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Tuberculosis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Gastrointestinal Disorders	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>					

Additional comments and/or medical conditions (current or otherwise) not listed:

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Are you currently taking any prescription or non-prescription medication? Yes  No

If yes, please provide details:

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#### DENTAL VISITS AND DENTAL HISTORY

Are you nervous during dental visits or treatment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever had an unfavourable dental experience?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever had complications from past dental treatment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever experienced a dental operation or procedure of any kind?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever had trouble getting numb or had reactions to local anesthetic?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you bruise easily or bleed severely when cut?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever worn braces? If yes, at what age: _____	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever had any teeth removed or had teeth that never developed?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do your gums bleed or are they painful when brushing or flossing?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever been treated for gum disease?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever noticed an unpleasant taste or odor in your mouth?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is there anyone with a history of periodontal disease in your family?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever experienced gum recession?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you had any cavities within the past 3 years?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have difficulty swallowing any food?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have problems with your jaw joint? (pain, sounds, locking, popping)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you feel or notice any holes on the biting surface of your teeth?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are any teeth sensitive to hot or cold temperatures?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you avoid or have difficulty chewing gum, nuts, or other hard, dry foods?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
In the past 5 years, have your teeth or bite changed (shorter, thinner)?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you chew ice, bite your nails, or have any other oral habits?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you wear or have you ever worn a bite appliance?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? Yes  No

Have you ever whitened (bleached) your teeth? Yes  No

Have you felt uncomfortable or self conscious about the appearance of your teeth? Yes  No

Have you been disappointed with the appearance of previous dental work? Yes  No

How often do you see a dentist? Every:                    3 months        6 months        12 months   

Name of Last Dentist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**ALLERGIES**

Are you allergic to, or have you had a reaction to, the following items?

Antibiotics	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Aspirin	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Codeine	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Darvon	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Local Anaesthetic	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Nitrous Oxide	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If you have ever been advised against, or had a reaction to, taking any type of medication, please list it:

\_\_\_\_\_

Please list any allergic conditions (e.g. asthma, hay fever, food allergies, latex allergy):

\_\_\_\_\_

**CHILDREN UNDER THE AGE OF 18 ONLY:**

Please list any medical conditions the child has recently had (e.g. measles, strep throat, tonsillitis etc.)

\_\_\_\_\_

**CONSENT**  
**COLLECTION OF PERSONAL INFORMATION**

Privacy of your personal information is an important part of providing you with quality dental care. We understand the importance of protecting your personal information and we are committed to collecting, using and disclosing your personal information responsibly. We collect personal information for the following purposes and mandate:

- Only necessary information is collected about you;
- We only collect, use, and share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation;
- We continuously review our policies and privacy protection protocols on an ongoing, annual basis to ensure that we comply with our obligations under various provincial legislation;
- We confirm that our privacy protocols comply with provincial privacy legislation and standards of our provincial regulatory body, as amended from time to time.

This office will collect, use and disclose information about you for the following purposes, including:

- To deliver safe and efficient patient care and to identify and to ensure continuous high-quality service.
- To assess your health and dental care needs and to advise you of treatment options
- To enable us to contact you and to establish and maintain communication with you.
- To communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists.
- To maintain communication with you to provide health care information and to book/confirm appointments.
- To allow us to efficiently follow-up for treatment, care and billing.
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to our provincial regulatory body, in a timely fashion.
- To invoice for goods and services and to process credit card payments.
- To comply with our obligations under applicable federal and provincial privacy legislation.

By signing the consent section of this Patient Consent Form below, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes included herein. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. Our office will not, under any conditions, supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly for your review, and for your specific consent. I have reviewed the above information that explains how your office will use and protect my personal information. I understand that I may withdraw my consent at any time, and, should I wish to do so, I will contact the clinic to inform them of this intention. I agree that my dental clinic or dental care provider, as outlined herein, can collect, use and disclose personal information for the purposes set out herein.

\_\_\_\_\_ Date

\_\_\_\_\_ Print Name

\_\_\_\_\_ Signature

**PATIENT ACKNOWLEDGEMENTS  
CANCELLATION POLICY**

It is the practice of our office to see all our patients on an appointment basis. We respect your time and make every effort to remain on schedule. We ask that you extend the same courtesy to us. If you are unable to keep your appointment, we request that you notify us at least 2 business days prior to your appointment. When you do so, we are able to offer your timeslot to another patient. Patients who fail to provide us with adequate notification time will be charged a missed appointment fee of \$50.00.

If you have any questions or require clarification, please contact our office.

I have read and understood the Cancellation Policy as outlined herein. I agree to the terms described and assume full liability for any fees charged should I fail to abide by these short notice requirements.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature

**INSURANCE INFORMATION RELEASE**

I authorize my insurance company to provide coverage information or pre-determination information required by my dental clinic or dental care provider, as outlined here, in order to provide me and/or all my dependants on this plan with necessary dental treatment as required by me.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature

**ELECTRONIC CLAIM AUTHORIZATION**

I understand that my claims may be submitted electronically, and I authorize the release, to my dental benefit carrier, of information contained in claims submitted electronically.

Date \_\_\_\_\_

Signature \_\_\_\_\_