PARKLAND DENTAL CENTRE

Confidential Patient Record

Medical / Dental Alert

_____

_____

Today's Date:_____

Personal Information

Patient's Name:_____ Sex: M / F Date of Birth:_____

Parent / Guardian (if under 18);_____

Mailing Address:_____Box #:_____

City / Town;_____ Province:_____Postal Code:_____

Telephone: Home:_____ Business:_____Cellular:_____

Email address: _____

Employed by:_____ How long_____ Occupation:_____

Personal Physician:_____ Telephone:_____

Name of nearest relative not living with you:_____ Telephone:_____

Address:_____Relationship:_____

Name of person responsible for account:_____ Birthdate:_____

Who referred you to our office:_____

Insurance Information

Do you have dental insurance? YES - CARD SCANNED / NO

Policy Holder:_____Insurer Name:_____Date of Birth:_____

Policy Group #:_____ Coverage %:_____ _____ _____ Division #:_____

Basic /Major / Endo

I.D. / Certificate / S.I.N. #:_____ _____ _____ _____

Deductible (Y / N)_____ Maximum per year:_____

Are you covered under a second plan?_____

Policy Holder:_____Insurer Name:_____Date of Birth:_____

Policy Group #:_____ Coverage %:_____ _____ _____ Division #:_____

Basic /Major / Endo

I.D. / Certificate / S.I.N. #:_____ _____ _____ _____

Deductible (Y / N)_____ Maximum per year:_____

Note: Dental Insurance is a private legal agreement between you and the insurance company. We submit claims on your behalf but hold no responsibility for limitations or procedures not covered. Insurance companies do not release information about the details of your plan to our office.

By signing, I agree to have dental claims submitted electronically on my behalf and I will assume responsibility for any and all fees associated with those procedures. I agree to allow the insurance company to release information about the details of my plan.

A service charge of 2% per month (24% annually) will be levied on all past-due amounts.
All collection fees (including legal fees) and related costs are my responsibility in the event of non-payment.

I have read & understand the above.

X_____

Patient / Parent or Gurardian Signature

Medical History

The following information is required to thooroughly diagnose any condition and to give the highest standard of professional services.
All information is strictly confidential.

Circle any of the following which you have had or have at present:

Heart failure
Heart Disease or Attack
Angina
High Blood Pressure
Date of last reading:_____
Heart Murmur
Rheumatic Fever
Congenital Heart Lesions
Scarlet Fever
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Artificial Joint
Hip / Knee Relacement
Anaemia
Blood Disorders
Stroke
Kidney Trouble
Ulcers
Emphysema
Prolonged Cough
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives

Diabetes (Juvenile , Type II)
Family History of Diabetes
Thyroid Disease
Cancer
Chemotherapy
Leukemia
Arthritis
Rheumatism
Cortisone Medication
Glaucoma
AIDS
Hepatitis A, B or C
Liver Disease
Yellow Jaundice
Blood Transfusion
Drug Addiction
Hemophillia
Venereal Disease
Cold Sores
Epilepsy or Seizures
Fainting or Dizzy Spells
Psychiatric Treatment
Extreme Nervousness
Frequent Severe Headaches
Pain of the Jaw Joints

List Allergies:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

General Health

1. Are you now under the care of a physician? Yes / No
2. Have you had or do you have any serious medical illness? Yes / No
3. Have you ever been hospitalized for an extended period of time?
   Yes / No If yes, please specify:_____
4. Have you had or presently have the following?
   Pain, pressure or tightness in the chest? Yes / No
   Swelling of ankles or feet? Yes / No
5. Have you been advised to take antibiotics before dental appointments?
6. Are you taking any drugs, medications or herbal supplements?
   Yes / No If yes, please indicate below:

_____
_____
_____
_____
_____

6. Do you use tobacco products? Yes / No
If yes, how often? _____
7. Are you taking any sexual enhancement medications?
(Viagra, Cialis, etc.,) Yes / No

Women

9. Are you pregnant? Yes / No
10. Are you taking any oral contraceptives or other hormones? Yes / No

Dental History

1. Have you had regular dental examinations in the past? Yes / No
   Date of last visit? _____
2. Have you ever had abnormal bleeding or other problems associated with previous dental extractions or surgery? Yes / No
3. Have you ever had any unusual reactions to fluoride, local anaesthetics or dyes? (if yes, please circle) Yes / No
4. Have you ever seen a dental specialist (periodontist, endodontist, prosthodontist)? Yes / No
5. Are you happy with the appearance of your teeth and gums? Yes / No
6. Are any of your teeth sensitive to heat, cold, sweets or pressure? Yes / No
7. Do you have any oral habits such as clenching, grinding your teeth, nail biting or sucking your thumb? Yes / No
8. Do you wake up with a sore jaw or jaw muscles? Yes / No
9. Do any teeth wake you up at night? Yes / No
10. Do you wear a night guard or have you ever been given one? Yes / No
11. Have you had professional tooth brushing/flossing instruction? Yes / No
12. How often do you brush your teeth daily? 1x / 2x / 3x / other
13. How often do you floss daily? 1x / 2x / 3x / other
14. Have you ever had an upsetting experience at a dental office, or any complications during or following dental treatment? Yes (explain below) / No
15. What are your dental concerns at this time?_____

_____
_____
_____
_____
_____

Patient Authorization:

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the Doctor of Dentistry at the next appointment without fail. In addition, this is to certify that I, the undersigned, consent to the performing of the dental procedures AGREED to be necessary or advisable, including the use of local anaesthetic as indicated and I will assume responsibility for any and all fees associated with those procedures.

X _____

Patient / Parent or Guardian Signature