Health Information **Name:**

Last Dental Visit: _____ Last Hygiene Visit: _____ Reason for TODAY'S visit: _____

List any medications and dosage (including Herbal)

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Name of Family Physician _____ **Name of Pharmacy** _____

Have you ever had any of the following? Please check those that apply:

Neural
- ☐ Epilepsy/Seizures
- ☐ Anxiety Attacks
- ☐ Depression
- ☐ Dizziness/Vertigo
- ☐ Mental Disorders
- ☐ Black outs
- ☐ Dementia/Alzheimer's
- ☐ Fibromyalgia

Pulmonary
- ☐ Asthma
- ☐ Difficulty breathing
- ☐ Respiratory problems
- ☐ COPD
- ☐ Emphysema

Cardiovascular
- ☐ Angina
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Arrhythmia

Digestive
- ☐ Acid reflux Disease
- ☐ Ulcers
- ☐ Crohn's Disease
- ☐ Colitis

Neoplastic
- ☐ Cancer/Tumors
- ☐ Radiation treatment
- ☐ Chemotherapy
- ☐ Immunotherapy

Immune
- ☐ Seasonal Allergies
- ☐ Food Allergies
- ☐ Medication Allergy
- _____
- ☐ Anaphylaxis

Inflammatory
- ☐ Arthritis/Rheumatism
- ☐ Gout

Infectious
- ☐ AIDS/HIV
- ☐ Hepatitis

Other
- ☐ Stroke
- ☐ Diabetes
- ☐ Artificial Joints
- ☐ Glaucoma
- ☐ Sinus Problems
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Sleep Apnea
- ☐ Organ Transplant
- ☐ Thyroid problems

Do you have any other medical conditions? _____

Surgeries or Hospitalizations 1. _____ year_____ 2._____ year_____

3._____ year_____ 4._____ year_____

HOW WOULD YOU RATE YOUR DENTAL ANXIETY? ☐ None ☐ Low ☐ Moderate ☐ High ☐ Severe

Dentist Notes:_____

_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you or anyone related to you ever had problems with dental anaesthetic? ☐ Yes ☐ No
  If yes please explain._____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
- Are you pregnant or is it possible you are pregnant_____ Due date_____ # of Weeks Pregnant _____
- Do you smoke? How many cigarettes a day? _____• If you used to smoke, when did you quit? _____
- Do you use Marijuana or any other recreational drugs? If so, please list which kind. _____
- Do you take antibiotics prior to dental work or surgery? ☐ Yes ☐ No
- Do you take any medication that thins your blood or affects clotting/bruising? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor(s) at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Referral Information

How did you learn about our practice?

☐ Walk-by / Location ☐ Internet/Website ☐ Radio ☐ Mouthguard Clinic

☐ Yellow Pages ☐ Other _____

☐ Person - Name of person or office referring you to our practice _____

Do you have a family Dentist elsewhere?_____

Consent for Services/ Office Agreement	**Please Initial**
*I understand that Georgian Shores Dental Centre is a non-assignment office. Assignment of benefits can be arranged separately.	_____
*I am required to **pay in full for my own/my family's treatment at each visit**. For treatment involving laboratory work, I will be required to place a deposit for the estimated lab work required (these are separate from Dental office fees).	_____
***My dental insurance plan is an agreement between myself and the organization providing me with the coverage**. Georgian Shores Dental Centre will help me to the best of their abilities to ensure accurate and timely completion of my insurance forms. It is however, my responsibility to ensure that the treatment I consent to is covered. I understand that I will be responsible for any fees that may not be covered by my insurance plan. Georgian Shores Dental Centre **does not have knowledge of what is covered by MY insurance plan**. Our treatment recommendations are based on your individual dental needs, not your insurance plan coverage.	_____
*Many plans require pre-determinations to be forwarded for more extensive treatment. Georgian Shores Dental Centre will aid me in sending and interpreting the pre-determination, however cannot be responsible for the accuracy of the insurance company reply.	_____
*I understand that Clinic time is valuable, and a minimum of **2 Full Business Days** notice must be given if I am/we are unable to attend these appointments, otherwise a standard rescheduling appointment fee of **$50.00** will be applied to my account.	_____
*In the event that there are outstanding account balances, they may be passed on to a Credit Agency for Collection, and the associated fees will be applied to your account.	_____
*Georgian Shores Dental Centre will propose my dental treatment with my long-term dental health in mind, and will do their best to give an accurate estimate. I understand that under some circumstances, unforeseen clinical situations may result in a change of the estimate.	_____

*** PLEASE INFORM THE STAFF IF YOU WOULD LIKE TO READ OUR OFFICE POLICY ON PRIVACY ***

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of Staff, Georgian Shores Dental Centre

Patient Information

Patient Name _____ Date _____
Last, First, MI, (Preferred Name)

Gender_____ Family Status_____

Birth Date _____ Age _____
day month year

Address: _____
Street Apartment #

_____ Postal Code_____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Email address: _____

Preferred Method of Contact: ☐ **Home** ☐ **Work** ☐ **Cell** ☐ **Email** ☐ **Text**

Are any of your immediate family members patients at our practice: ☐ No ☐ Yes Name: _____

Responsible Party Information
Insurance Information

Party Responsible for Insurance ☐ **Self** ☐ **Other** _____
Relation

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City Province Postal Code

Name of Insurance Company: _____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City Province Postal Code

Name of Insurance Company: _____