pine FAMILY DENTAL

PERSONAL INFORMATION

Surname _____ First Name _____

Middle Name _____ Preferred Name _____

Date of Birth (YYYY/MM/DD) _____ Gender _____

Address _____ City _____

Province _____ Postal Code _____ Email _____

Phone (Home) _____ (Cell) _____ (Work) _____

Preferred Method of Contact *(please circle)* Phone (Home / Cell / Work) Email

How did you hear about our practice? If a friend or family member referred you, please share their name so we can thank them for their confidence is recommending our office.

_____

INSURANCE

Primary Insurance Company _____

Plan/Policy/Group _____ ID/Certificate _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Secondary Insurance Company _____

Plan/Policy/Group _____ ID/Certificate _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

I authorize Pine Family Dental to communicate with my insurance company on my behalf, and when applicable, hereby assign my benefits payable to Pine Family Dental. I understand that I am financially responsible for the total payment of all procedures performed in this office. This includes any treatment that is not a benefit of any dental insurance company.

Signature _____ Signature of Parent / Guardian _____

MEDICAL HISTORY

Are you being treated for any medical condition at present or have you been treated within the past year?

If so, why? YES NO

_____

When was you last medical check up? _____

Has there been any change in you general health in the past year? If yes, please explain. YES NO

_____

Are you taking any medication, non-prescription drugs or herbal supplements? YES NO

If yes, please list. _____

Do you have any allergies? If yes, please list using the categories below. YES NO

a) Medications
b) Latex/rubber products
c) Other (e.g. hay fever, foods)

_____

Have you ever had a peculiar or adverse reaction to any medication or injection? YES NO

If yes, please explain. _____

Do you have or have you ever had asthma? YES NO

Do you have or have you ever had any blood pressure problems, Diabetes or high cholesterol? YES NO

Do you have or have you ever had a replacement/repair to a heart valve, infection of the heart (infective endocarditis), heart condition from birth (congenital heart disease) or heart transplant?

YES NO

Do you have a prosthetic or artificial joint? YES NO

Do you have any conditions / therapies that could affect you immune system? If yes, please circle YES NO

(e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)

Have you ever had hepatitis, jaundice or liver disease? YES NO

Do you have a bleeding problem or disorder? YES NO

MEDICAL HISTORY cont'd

Have you ever been hospitalized for any illness or operations? YES NO

If yes, please explain _____

Do you have or have you ever had any of the following? If yes, please circle.

Chest pain/angina	Rheumatic fever	Pacemaker	Steroid Therapy	Seizures (epilepsy)
Heart attack	Mitral Valve Prolapse	Lung Disease	Diabetes	Kidney Disease
Shortness of breath	Tuberculosis	Stomach ulcers	Osteoporosis Medication (e.g. Fosamax, Actonel)	
Stroke	Heart murmur	Cancer	Arthritis	Drug/Alcohol Dependency

Do you have any disease, condition or problem not listed above? YES NO

Do you smoke or use tobacco? If yes, how much per day? YES NO

Women, are you pregnant or taking oral contraceptives? YES NO

If yes, please explain _____

Physician (Name) _____ (Phone) _____

Emergency Contact (Name)_____ (Phone) _____

DENTAL HISTORY

Reason for visit _____

When was your last dental visit? _____ Were any x-rays taken? _____

Previous Dentist (optional) _____(Phone)_____

Do your gums bleed while brushing or flossing?	YES	NO
Are your teeth sensitive to hot or cold liquids or food?	YES	NO
Do you clench or grind your teeth?	YES	NO
Have you ever had an injury to your head, neck, jaws or teeth?	YES	NO

If yes, please explain _____

Have you had problems with prior dental treatment?	YES	NO

If yes, please explain _____

To the best of my knowledge all of the above information is accurate and complete. I understand that this information is held in the strictest confidence, and it is my responsibility to inform the office of any changes to medical or insurance status. I understand that 24 hours notice must be given to change or cancel an appointment, or a $50 fee may apply. I give permission to share my personal, medical and dental history with other dental specialists that are involved in my care and wellbeing. I consent to having my photo taken for clinical records and personal identification purposes.

Signature _____ Date_____

Signature of Parent / Guardian _____