WEST MISSISSAUGA DENTAL

CARE · TRUST · CONFIDENCE

Welcome!

Medical Alert ☐

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. **PLEASE PRINT.**

Patient Information

A parent or guardian will be responsible for decisions on my treatment: ☐ **Yes** ☐ **No**

Title: Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Mst. ☐

Name: _____
First Initial Last Prefer to be called

Address: _____
Street Apt. # City Province Postal Code

Marital Status: _____ Date of Birth: ____/____/____ Email: _____
D M Y

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

Health Card Number: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Tel. (____) _____

Family Physician: _____ Tel. (____) _____

Medical Specialist: _____ Tel. (____) _____

Whom may we thank for referring you to our office? _____

If not referred, how did you choose our office? Google ☐ Mailer ☐ Storefront Sign ☐ Facebook ☐ Other ☐ _____

Financial Information

Method of payment: Cash ☐ Credit Card ☐ Other ☐

Person responsible for account: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

IF DIFFERENT FROM ABOVE

Name: _____
First Initial Last

Address: _____
Street Apt. # City Province Postal Code

Date of Birth: ____/____/____ Home Phone (____) _____ Work Phone (____) _____
D M Y

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have provided is accurate and complete, and that I have not knowingly omitted any information. Should there be any change in my health status in the future, I will advise this dental office immediately. I consent to the release of medical information from or to my medical doctor or another health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____

Signature ☐ Self ☐ Parent/Guardian Print name Date

Medical History

(This information will remain confidential.) Date _____

	YES	NO
1. Are you presently under the care of a physician? If so, explain. _____	☐	☐
2. Have you ever been hospitalized? Explain. _____	☐	☐
3. Are you taking any drugs or medication at this time (prescription or non-prescription, incl. herbal remedies)? -----	☐	☐

A) Drug _____ Reason _____ D) Drug _____ Reason _____

B) Drug _____ Reason _____ E) Drug _____ Reason _____

C) Drug _____ Reason _____ F) Drug _____ Reason _____

4. Have you ever had any adverse effect from any of the following: Antibiotics – Penicillin ☐ Sulphonamide ☐ Other ☐

Aspirin ☐ Barbiturates (sleeping pills) ☐ Codeine ☐ Darvon ☐ Local Anaesthetic ☐ NONE ☐.

5. Have you ever been warned against using any other medications? Which?_____	☐	☐
6. Have you ever taken prolonged medical or non-medical drugs? Which? _____	☐	☐
7. Do you suffer from any allergies (hay fever, metal or latex, etc.)? Which?_____	☐	☐
8. Do you bruise easily or have prolonged bleeding? ----------	☐	☐
9. Do you smoke? Did you smoke in the past? How much per day?_____For how many years?_____	☐	☐
10. Have you ever fainted or had shortness of breath or chest pains? ----------	☐	☐

11. **WOMEN:** Are you pregnant? Yes☐ No☐ Using birth control? Yes☐ No☐ Reached menopause? Yes☐ No ☐

12. Do you have or have you ever had any of the following? Please appropriate boxes. **NONE** ☐

☐ A.I.D.S.	☐ Cortisone/steroid	☐ High/Low Blood pressure	☐ Psychiatric disorders
☐ Anemia	☐ Diabetes	☐ H.I.V. Positive	☐ Radiation/Chemotherapy
☐ Angina pectoris	☐ Drug/alcohol dependence	☐ Hodgkin's disease	☐ Rheumatic/Scarlet fever
☐ Anorexia nervosa	☐ Emphysema	☐ Hyper (Hypo) Glycaemia	☐ Sickle Cell disease
☐ Artificial Heart valve	☐ Epilepsy or Seizures	☐ Hypertension	☐ Sinus trouble
☐ Arthritis/rheumatism	☐ Glandular disorders	☐ Jaundice	☐ Stomach/intestinal problems
☐ Artificial joints (hips, knees)	☐ Glaucoma	☐ Kidney disease	☐ Stroke
☐ Asthma	☐ Head/Neck injuries	☐ Liver disease	☐ Thyroid disease
☐ Blood disorders	☐ Heart disease/attack	☐ Leukemia	☐ Tuberculosis
☐ Bronchitis	☐ Heart murmur	☐ Lung disease	☐ Ulcers
☐ Bulimia	☐ Heart pacemaker/surgery	☐ Malignant hypothermia	☐ Venereal disease
☐ Cancer	☐ Heart rhythm disorder	☐ Mental/nervous disorder	☐ Other _____
☐ Circulation problems	☐ Hepatitis A/B/C	☐ Mitral valve prolapse	☐ Other _____
☐ Congenital heart lesions	☐ Herpes	☐ Organ transplant/implant	☐ Other _____

13. **CHILDREN** Have you had any of the following (indicate approximate date)?

☐ Chicken Pox _____ ☐ Measles _____ ☐ Mumps _____

☐ Strep Throat _____ ☐ Tonsillitis _____ ☐ NONE

Dental History

1. What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other _____
2. How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Other _____
3. When was your last dental visit? _____ Last hygiene visit? _____ Last X-Ray? _____
4. How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____
5. Are any of your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Pressure ☐ Other _____
6. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never

	YES	NO
7. Do your gums feel swollen or tender?----------	☐	☐
8. Do you have bad breath or a bad taste in your mouth?----------	☐	☐
9. Do your jaws crack, pop or grate when you open widely?----------	☐	☐
10. Do you grind or clench your teeth (day or night)? ----------	☐	☐
11. Do you have food catch between your teeth? ----------	☐	☐
12. Have you ever had local anaesthetic (freezing)? ----------	☐	☐
Any complications? Specify_____	☐	☐
13. Have you ever had any problems with previous dental treatments? Specify_____	☐	☐
14. Have you been advised to take antibiotics before a dental appointment?----------	☐	☐
15. Are you interested in sedation for your dental treatment? ----------	☐	☐

16. Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps ☐ Implants

☐ Full or Partial Dentures ☐ Orthodontics (braces) ☐ Periodontal treatment/Gum Surgery ☐ Root Canals

17. Are you satisfied with your teeth? Specify_____	☐	☐
18. Are you interested in Invisalign (clear aligners)?	☐	☐

Thank You

WEST MISSISSAUGA
DENTAL
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COLLECTION OF ACCOUNT BALANCES

Dear valued patient, we would like to take a moment to outline your responsibility for your payment of dental treatments that have not been covered by your dental insurance. While we do our best to secure the correct information and submit claims on your behalf, insurance coverage can vary and there may be instances where certain treatments are not fully covered.

In such cases, you may be responsible for paying the remaining balance for the treatment. We understand that unexpected bills can be difficult, which is why we want to make sure you are aware that it could take up to 12 months for payment to arrive to our dental office.

If for any reason payment does not arrive, we may need to ask for your payment well after your treatment. We apologize for any inconvenience this may cause and want to assure you that we will work with you to find a payment solution that works for you.

We value your trust in us and your dental care provider and want to thank you for your understanding and cooperation. If you have any questions or concerns regarding your billing statement, please do not hesitate to contact us.

Sincerely,
West Mississauga Dental

Signature: _____

Name (Print):_____

Witness: _____

Date: _____