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We	come!		CARE·TRUST·CONFIDENCE Medical Alert				
• •							
-	1 0	, we would ask that you complet A parent or guardian will be resp	-	-	-	E PRINT. Yes 🗆 No	
				-			
Title: Dr.	□ Mr. □ Mrs. □	Ms. Miss Miss.					
Name:							
	First	Initial		Last	Prefer	to be called	
Address: _	Street	Apt. #	City	Prov	ince Postal	Code	
		Date of Birth: $\frac{/}{D} \frac{/}{M}$	•				
Home Pho	one: ()	Cell Phone ()		Work Ph	one ()		
Health Car	rd Number:						
Employer:	:	0	ccupation:				
Emergenc	y Contact:			Tel. ()		
			Tel. ()				
Medical S	pecialist:			Tel. ()		
Whom ma	y we thank for referrin	g you to our office?					
	-	se our office? Google 🗌 Maile	er 🗆 Storefront S	Sign 🗆 Faceb	ook 🗌 Other 🗆		
Financ	cial Information	Method of payment:	Cash 🗆 — — C	redit Card 🗆	Other		
		Person responsible for	account: Self 🗆	Spouse 🗆	Parent/Guardian	Other 🗆	
	Name:						
IF DIFFER-	Fi	rst Initial		La	ist		
ENT FROM ABOVE	Address:	reet	Apt. #	City	Province	Postal Code	
	Date of Birth:/	/ Home Phone (Work	Phone ()		
		GENERAL	DELEASE				

KAL KELEASE

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.

Medical History

(This information will remain confidential.)

Date

1. Are you presently under the care of a physician? If so, explain.		VES NO								
2. Have you ever been hospitalized? Explain.	1. Are you presently under the care of a physician? If so, explain,	$\begin{array}{c c} \mathbf{YES} & \mathbf{NO} \\ \hline \end{array}$								
3. Are you taking any drugs or medication at this time (prescription or non-prescription, incl. herbal remedies)? <pre></pre>										
A) Drug Reason D) Drug Reason B) Drug Reason D) Drug Reason C) Drug Reason D) Drug Reason Aspirin Babiturates (sleeping pills) Codeine Darvon Local Anaesthetic Ohr Aspirin Babiturates (sleeping pills) Codeine Darvon Local Anaesthetic Ohr Aspirin Babiturates (sleeping pills) Codeine Darvon Local Anaesthetic Ohr Aspirin Babiturates (sleeping pills) Codeine Darvon Local Anaesthetic Ohr Aspirin Babiturates (sleeping pills) Codeine Darvon Local Anaesthetic Ohr Do you sunke? Didy ou snoke in the past? Hor Ohr Ohr Dave you ever faind of Dabetos NoNE Didy of Dabetos NoNE Didy of Dabetos Didy of Dabetos NoNE Didy of Dabetos Didy of	y 1 1 <u> </u>									
B) Drug Reason F) Drug Reason C) Drug Reason F) Drug Reason 4. Have you ever had my adverse effect from any of the following: Antibioties – Penicillin Sulphonamide Other Aspirin Barbiurates (sleeping pills) Codeine Darvon Local Anaesthetic NONE . 5. Have you ever taken prolonged medical or non-medical drugs? Which?		· · · · · · · · · · · · · · · · · · ·								
C) Drug Reason [1] Drug Reason 4. Have you ever had any adverse effect from any of the following: Antibiotics - Penicillin Stuphonamide Other Aspirin Barbiturates (sleeping pills) Codeinc Darvon Local Anaesthetic NONE 5. Have you ever taken prolonged medical drugs? Which?	B) Drug Reason E) Drug	Reason								
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Aspirin Barbiturates (sleeping pills) Codeinc Darvon Local Anaesthetic NONE 5. Have you ever hearn polonged medical on non-medical fuegy? Which?										
5. Have you ever been warned against using any other medical drugs? 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?	7. Do you suffer from any allergies (hav fever, metal or latex, etc.)? Which?									
9. Do you smoke? Did you smoke in the past? How much per day?For how many years?	8. Do vou bruise easily or have prolonged bleeding?	□								
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 Psychiatric disorders 14. LDS. Coisonc/storoid High/Low Blood pressure Psychiatric disorders 14. Andmain Diabetes H.U. Positive Psychiatric disorders 15. Anorexia nervosa Emphysema Phyper (Hypo) Glycennia Sickle Cell disease 16. Artificial fleart valve Eplepsy or Szizures Hyper (Hypo) Glycennia Sickle Cell disease 16. Artificial joints (hips, kness) Glaucoma Kithrey disease Bitod disorders Bitod disorders Head/Neck injuries Liver disease Thyroid disease 16. Concer Heart murnur Lung disease Other Other Other 17. Ciculation problems Heart hythm disorder Mental/nervous disorder Other Other Other 18. Od disorder brox Heart hythm disorder Other Other Other Other 13. CHILDREN Have you had any of the following (indicate approximate date)? Mumps NONE 24. How often do you brush per day? <	10. Have vou ever fainted or had shortness of breath or chest pains?	□								
12. Do you have or have you ever had any of the following? Please appropriate boxes. NONE A1.D.S. Cortisone/steroid High/Low Blood pressure Psychiatric disorders Anerexia nervosa Drug/alcohol dependence Hodgkin's disease Psychiatric disorders Anorexia nervosa Epplepsy or Seizures Hyper (Hypo) (Psyceamia Sinus trouble Arthritishrheumatism Glaucoma Kidney disease Sinus trouble Arthritishrheumatism Glaucoma Kidney disease Drubroid disease Bronchitis Heart murmur Lug disease Dubroid disorders Balimia Heart pacemaker/surgery Malignant hypothermia Other Cancer Heart phythm disorder Mental/nervous disorder Other Congenital heart lesions Hepresitis A/B/C Organ transplant/implatin Other 13. CHILDREN Have you had any of the following (indicate approximate date)? Mumps Strep Throat Ossa Anorexis NONE Dental History How oftequently do you see a dentist? 3-6 months Annotally Other 14. What is the reason for today's visit? Emergency Examination Other Other </td <td></td> <td></td>										
□ A.LD.S. □ Cortisone/steroid □ High/Low Blood pressure □ Psychiatric disorders □ Anemia □ Drug/alcohol dependence □ Hodgkin's disease □ Rheumatic/Scarlet fever □ Anemia □ Drug/alcohol dependence □ Hodgkin's disease □ Rheumatic/Scarlet fever □ Antrificial Heart valve □ Epilepsy or Seizures □ Hypert(Hypo) Glycaemia □ Stickle Cell disease □ Artificial joints (hips, knees) □ Glaucoma □ Kidney disease □ Storach/intestinal problems □ Astima □ Edatoma □ Kidney disease □ Thyroid disease □ Thyroid disease □ Balimia □ Heart mythm disorder □ Malignant hypothermia □ Ucers □ Ucers □ Bulimia □ Heart mythm disorder □ Mental/nervous disorder □ Other □ Other □ Congenital heart lesions □ Heart mythm disorder □ Mental/nervous disorder □ Other □ Other □ Chicken Pox □ Heart mythm disorder □ Mental/nervous disorder □ NoNE □ □ Chicken Pox □ Tonsillitis □ NONE □ □ □ Strep Throat □ Tonsillitis □ NONE □ □ An was your last dental visit? □ 4 monts □ Anemia/so										
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Asthma Head/Neck injuries Liver disease Thyroid disease Blood disorders Heart disease/attack Leukemia Tuberculosis Bronchitis Heart marmur Lung disease Ulcers Cancer Heart mythm disorder Metal/nervous disorder Other Circulation problems Hepatitis A/B/C Mitral valve prolapse Other Congenital heart lesions Herpes Organ transplant/implant Other Strep Throat Tonsillitis NONE Dental History Strep Throat Tonsillitis NONE What is the reason for today's visit? Emergency Examination Other When was your last dental visit? Ja-6 months Annually Other When was your last dental visit? Floss? Use anti-bacterial rinse? Are any of your teeth sensitive to: Cold Sweets Heat Pressure Other Do you gums bleed when: Brushing Flossing Never YES NO Do you gums feel swollen or theder?	□ Arthritis/rheumatism □ Glandular disorders □ Jaundice □ Stomac	h/intestinal problems								
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6. Do your gums bleed when: Brushing Flossing Never YES NO 7. Do your gums feel swollen or tender?										
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)? □ 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: □ □ 16. Have you ever had any of the following: □ □										
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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)? □ 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: □ □ □ □ □ □ □ □ □ □ □										
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12. Have you ever had local anaesthetic (freezing)? Any complications? Specify I Have you ever had any problems with previous dental treatments? Specify I I I <t< td=""><td></td><td></td></t<>										
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 □										
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 □										
16. Have you ever had any of the following: \Box Bridgework \Box Crowns or Caps \Box Implants										
$ \Gamma U 0 \Gamma U U U U U U U U U $	□ Full or Partial Dentures □ Orthodontics (braces) □ Periodontal treatment/Gum Surger									
17. Are you satisfied with your teeth? Specify □		•								
18. Are you interested in Invisalign (clear aligners)?	• • • • •									



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:	