Dentrix DentalCare

Patient Information

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

Gender: M / F Martial Status Married / Single / Child / Other

Social Insurance #: _____ Birth Date:(dd/mm/yr)_____

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

Address:

_____
_
Street City Prov. Postal Code

Email Address: _____
(Appointment times can be confirmed by e-mail)

Insurance Information

Primary

Name of Insured: _____
is insured a patient? ☐ Yes ☐ No

Insurance Plan Name:_____

Insured's Birth Date: _____

ID #: _____ Group #: _____

Secondary

Name of Insured:_____
is insured a patient? ☐ Yes ☐ No

Insurance Plan Name:_____

Insured's Birth Date: _____

ID #: _____ Group #: _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend, relative ☐ Website ☐ Google
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____
We do appreciate any referrals!

Consent for Service

The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patients dental needs. I also authorize the doctor to perform any and all forms of treatment, medications, and therapy that may be indicated as mutually agreed upon. I understand that during a procedure circumstances may dictate a change in technique or additional fees which I am responsible for. The below signature also authorizes Dentrix DentalCare the permission to forward any needed information, which includes Health history & X-rays, to any office which I may be referred to for further treatment.

_____ **Printed name:**_____
Signature of Patient, Parent or Guardian

Date:_____ **Relationship to patient:**_____

Appointment Policy Please Read and Initial

In order to be fair to both our team members and to all of our patients, we do require that you notify our office with at least two business days (48hrs) notice for any appointment changes or cancellations. Failure to provide this notice will result in a $66.00 per hour missed appointment charge.
If multiple appointments are missed, a non refundable fee may be charged prior to another appointment being booked.

Initials _____

MEDICAL HISTORY

Patient Name_____ Nickname_____ Age_____

Name of Physician / and their specialty _____

Most recent physical examination_____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

1	Hospitalization for illness or injury	Yes	☐	No	☐	25	Diabetes (TYPE-_____)	Yes	☐	No	☐
2	An allergic reaction to:					26	Stomach or duodenal ulcer	Yes	☐	No	☐
a.	Aspirin, ibuprofen, acetaminophen, codeine	Yes	☐	No	☐	27	Digestive disorders (i.e. gastric reflux)	Yes	☐	No	☐
	b. Penicillin	Yes	☐	No	☐	28	Osteoporosis/osteopenia (i.e. taking bisphosphonates)	Yes	☐	No	☐
	c. Erythromycin	Yes	☐	No	☐	29	Arthritis	Yes	☐	No	☐
	d. Tetracycline	Yes	☐	No	☐	30	Glaucoma	Yes	☐	No	☐
	e. Sulpha	Yes	☐	No	☐	31	Contact lenses	Yes	☐	No	☐
	f. Local anesthetic	Yes	☐	No	☐	32	Head or neck injuries	Yes	☐	No	☐
	g. Fluoride	Yes	☐	No	☐	33	Epilepsy, convulsions (seizures)	Yes	☐	No	☐
	h. Metals, (nickel, gold, silver, _____)	Yes	☐	No	☐	34	Neurologic problems (attention deficit disorder)	Yes	☐	No	☐
	i. Latex	Yes	☐	No	☐	35	Viral infections and cold sores	Yes	☐	No	☐
	j. Other _____	Yes	☐	No	☐	36	Any lumps or swelling in the mouth	Yes	☐	No	☐
3	Heart problems or cardiac stent within the last six months	Yes	☐	No	☐	37	Hives, skin rash, hay fever	Yes	☐	No	☐
4	History of infective endocarditis	Yes	☐	No	☐	38	Venereal disease	Yes	☐	No	☐
5	Artificial heart valve, repaired heart defect (PFO)	Yes	☐	No	☐	39	Hepatitis (type_____)	Yes	☐	No	☐
6	Pacemaker or implantable defibrillator	Yes	☐	No	☐	40	HIV / AIDS	Yes	☐	No	☐
7	Artificial prosthesis (heart valve or joints)	Yes	☐	No	☐	41	Tumor, abnormal growth	Yes	☐	No	☐
8	Rheumatic or scarlet fever	Yes	☐	No	☐	42	Radiation therapy	Yes	☐	No	☐
9	High or low blood pressure	Yes	☐	No	☐	43	Chemotherapy	Yes	☐	No	☐
10	A stroke (taking blood thinners)	Yes	☐	No	☐	44	Emotional problems	Yes	☐	No	☐
11	Anemia or other blood disorder	Yes	☐	No	☐	45	Psychiatric treatment	Yes	☐	No	☐
12	Prolonged bleeding due to a slight cut (INR>3.5)	Yes	☐	No	☐	46	Antidepressant medication	Yes	☐	No	☐
13	Emphysema, sarcoidosis	Yes	☐	No	☐	47	Alcohol / drug dependency	Yes	☐	No	☐
14	Tuberculosis	Yes	☐	No	☐	**ARE YOU:**					
15	Have you had recent exposure to communicable infectious diseases (measles, chicken pox, TB, Prion disease, or travel to endemic area)	Yes	☐	No	☐	48	Presently being treated for any other illness	Yes	☐	No	☐
16	In the last 24 hours have you had new cough, shortness of breath, fever, chills, diarrhea or other flu like symptoms	Yes	☐	No	☐	49	Aware of a change in your general health	Yes	☐	No	☐
17	Asthma	Yes	☐	No	☐	50	Taking medication for weight management (i.e. fen-phen)	Yes	☐	No	☐
18	Breathing or sleep problems (i.e. snoring, sinus)	Yes	☐	No	☐	51	Taking dietary supplements	Yes	☐	No	☐
19	Kidney disease	Yes	☐	No	☐	52	Often exhausted or fatigued	Yes	☐	No	☐
20	Liver disease	Yes	☐	No	☐	53	Subject to frequent headaches	Yes	☐	No	☐
21	Jaundice	Yes	☐	No	☐	54	A smoker or smoked previously	Yes	☐	No	☐
22	Thyroid, parathyroid disease, or calcium deficiency	Yes	☐	No	☐	56	Often unhappy or depressed	Yes	☐	No	☐
23	Hormone deficiency	Yes	☐	No	☐	57	FEMALE – taking birth control pills	Yes	☐	No	☐
24	High cholesterol or taking statin drugs	Yes	☐	No	☐	58	FEMALE – pregnant	Yes	☐	No	☐
						59	MALE – prostate disorders	Yes	☐	No	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins you are currently taking.

Drug	Purpose	Drug	Purpose

_____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING. Patient's Signature_____

Date_____