

DATE: \ / \ / \ /

PATIENT INFORMATION

PATIENT IS AN: ADULT CHILD ADULT UNDER GUARDIANSHIP NAME OF GUARDIAN: _____

Name _____ (last) _____ (first) _____ (initial) Nickname _____ Mrs. Ms Mr.

Home Address _____ (street) _____ (city) _____ (prov.) _____ (postal code)

Home Phone () _____ Cellular Phone () _____ Fax # () _____

Date of Birth: \ / \ / \ / Age: _____ Sex: _____ Marital Status: _____

Driver's License # _____ email: _____

Family Physician: _____ Phone: () _____

Medical Specialist (if presently under care) _____ Phone: () _____

OCCUPATION: _____

Employed By: _____ Phone () _____ Ext. _____

Spouse Employed By: _____ Phone () _____ Ext. _____

DENTAL INSURANCE Yes No Group Policy # _____ Certif. # _____

Primary Insurance Co. Name: _____ Yr. End _____

Coverage: Basic % Prosthetics % Crown/Bridge % Ortho % Perio Scaling %

Secondary Ins Co Name _____ Group Pol # _____ Certif.# _____ Yr. End _____

Coverage: Basic % Prosthetics % Crown/Bridge % Ortho % Perio Scaling %

PERSON RESPONSIBLE FOR ACCOUNT Self Other Name: _____

Address _____

Home Phone () _____ Business Phone () _____

IN CASE OF EMERGENCY Please Notify _____ Relationship _____

Home Phone: () _____ Business Phone: () _____ Ext. _____

Is any other member of your family or relative a patient at our office? _____

REASON FOR TODAY'S VISIT Examination Emergency Other _____

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

MEDICAL HISTORY	PLEASE CHECK YES OR NO. IF NOT SURE, CHECK NS.	NO	NS	YES
Are you presently under Doctor's care? Why?				
Have you been under Doctor's care in the past two years? Why?				
Have you taken any medications, pills or drugs in the past two years?				
Are you presently taking any medications, pills or drugs?				
Are you presently taking any Natural Supplements? e.g., Vitamins or Herbs				⇒ If YES, list them here:
Have you ever had Tonsillitis?				⇒
Have you been hospitalized in the past two years? (If yes, why?)				
Have you had any type of surgery? What & When?				
When was your last complete physical examination?				
When walking, do you ever have to stop because of pain in your chest or shortness of breath?				
Are you on a prescription diet?				
Have you ever been diagnosed as having a tumor or cancer?				
Have you ever taken cortisone/steroid medication?				
Do you experience problems with healing?				
Do you wish to speak privately with the Doctor about any problem?				
Do you smoke? (If yes, how much?)				
Are you currently in good health?				
Do you bruise easily or bleed excessively?				
Have you ever been warned about anaesthetic risks?				

MEDICAL ALERT	<u>CONDITION</u>	<u>PREMEDICATION</u>	<u>ALLERGIES</u>	<u>ANAEST.</u>
----------------------	------------------	----------------------	------------------	----------------

ALLERGIES Please check off any medications you are allergic to or you have reacted adversely to:

<input type="checkbox"/> Ibuprofen (Advil)	<input type="checkbox"/> Nembutal	<input type="checkbox"/> Demerol	<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Rovamycin	<input type="checkbox"/> Local Anaesthetic (Freezing)
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Seconal	<input type="checkbox"/> Percodan	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Cephalixin	<input type="checkbox"/> Nitrous Oxide
<input type="checkbox"/> Tylenol	<input type="checkbox"/> Naproxen	<input type="checkbox"/> Darvon	<input type="checkbox"/> Clindamycin	<input type="checkbox"/> Sulpha Drugs	<input type="checkbox"/> Amoxicillin
<input type="checkbox"/> Tylenol #2, #3, #4	<input type="checkbox"/> Toradol	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Scopolamine	<input type="checkbox"/> Metal	<input type="checkbox"/> Chlorhexidene (Peridex)
<input type="checkbox"/> 222, 282, 292	<input type="checkbox"/> Codeine	<input type="checkbox"/> Valium	<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Latex	<input type="checkbox"/> Bandage

Food Allergies, please list:

Please list any other medications or substances which you know you are allergic to:

MEDICAL CONDITIONS Please check off all of the following conditions you presently have, or have had. (If not sure, check off NS)

	No	NS	Yes		No	NS	Yes		No	NS	Yes
Malignant Hyperthermia				Scarlet Fever				Rheumatic Fever			
Stomach/Intestinal Problems				Kidney Trouble				Artificial Joints/Hips			
Transdermal Nicotine Patches				Ulcers				Diabetes or Hypoglycemia			
High Blood Pressure/Hypertension				Asthma				Arthritis/Rheumatism			
Low Blood Pressure				Hay Fever				Epilepsy or Seizures			
Heart Failure				Sinus Trouble				Glandular Disorders			
Congenital Heart Lesion				Emphysema				Psychiatric Care			
Artificial Heart Valve				Frequent Cough				Mental/Nervous Disorders			
Heart Pacemaker				Lung Disease				AIDS(HIV Positive)			
Heart Surgery				Bronchitis				Venereal Disease			
Heart Murmur				Tuberculosis				Herpes			
Mitral Valve Prolapse				Liver Disease				Cold Sores			
Chest Pain				Hepatitis A (infect.)				Fever Blisters			
Angina Pectoris				Hepatitis B (serum)				Blood Disorders			
Shortness of Breath				Hepatitis C				Circulation Problems			
Stroke				Yellow Jaundice				Sickle Cell Anemia			
Fainting or Dizziness				Thyroid Disease				Hemophilia			
Anemia				Glaucoma				Cancer			
Cardiac Arrest/ Heart Attack				Pain in Jaw Joints				Chemotherapy/Radiation			
Swelling of Feet/Ankles/Hands				Head/Neck Injuries				X-Ray/Cobalt Treatment			
Drug or Alcohol Addiction				If Yes, have you received treatment?		Where?					

Is there anything we have not mentioned that you think we should know regarding your medical history?

WOMEN ONLY	Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you taking Birth Control Pills? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Are you nursing? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you taking Fertility drugs? Yes <input type="checkbox"/> No <input type="checkbox"/>

Follow-up information to above questions:

MEDICAL ALERT	CONDITION	PREMEDICATION	ALLERGIES	ANAEST.
----------------------	------------------	----------------------	------------------	----------------

PATIENT NAME:	CHART NO:	DATE:
----------------------	------------------	--------------

REASON FOR INITIAL VISIT:

LAST DENTAL VISIT: Date: \ \	LAST DENTAL CLEANING: Date: \ \	PREVIOUS DENTIST:
M D Y	M D Y	

Please check YES or NO. If not sure, please check NS.

	NO	NS	YES		NO	NS	YES	
Are you suffering from pain now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ORAL HYGIENE				
Are any of your teeth becoming loose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use Dental aids?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have any of your teeth shifted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use any fluoride/mouth rinses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Does food get caught between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you happy with appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are any teeth sensitive to: cold <input type="checkbox"/> hot <input type="checkbox"/> biting <input type="checkbox"/> pressure <input type="checkbox"/> sweet <input type="checkbox"/> bitter <input type="checkbox"/>				What would you like to change about your teeth?				
Is there any swelling or pain of your gums?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush your teeth?				
Is there a history of gum disease in your family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss your teeth?				
Are you aware of sores/growths in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Do you notice any bleeding from your gums when you brush your teeth, or other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	JAW PROBLEMS	Do you have any of the following?	NO	NS	YES
Have you had a local anaesthetic (freezing)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clicking/popping of jaw when opening/closing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
....any complications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain (in jaw joints - ear, side of face)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any teeth extracted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in opening or closing your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
....any complications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain and/or difficulty in chewing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have burning sensation of lips or tongue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain when cleaning your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Does your mouth tend to get dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had implant surgery in one or both of your jaw joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have bad taste in your mouth or bad breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, who performed the surgery and when was it done?				
Are you nervous about having dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Have you ever had an upsetting experience in a Dental office?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
EXPLAIN:				Are you being followed-up by a dental specialist?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

HABITS	Do you -	NO	NS	YES	TREATMENTS	Please check off the following treatments you have had:	NO	NS	YES
Clench or grind your teeth while asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment (braces)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bite your lips or cheeks regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oral surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment (gum surgery)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Breath through your mouth while awake or asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Teeth ground or bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Worn a bite plate or other appliance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					Dental implants?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

GENERAL CONSENT STATEMENT

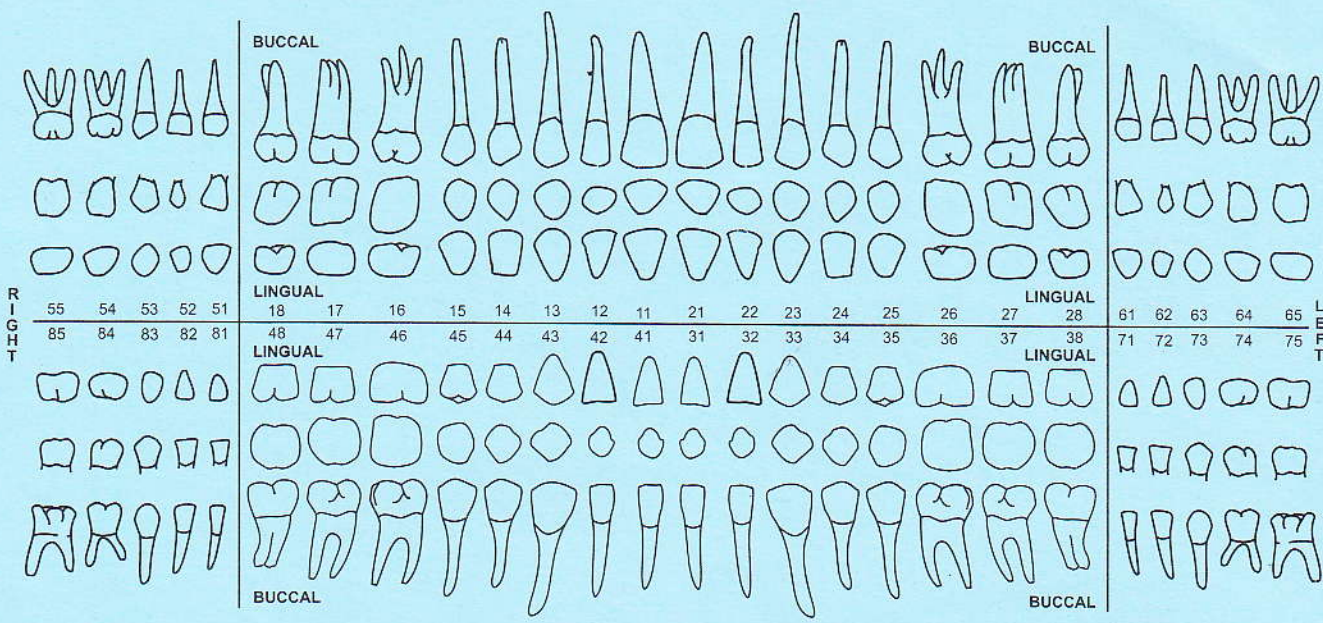
I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general or local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive. I know that your office has a privacy code, and I can ask to see the code at any time. I agree that your office can collect, use and disclose personal information about me as set out in your office privacy policy.

Patient Parent Guardian Date: _____ Signature: _____

I wish to pay each visit as services are performed Cash Cheque Interac Credit Card Other

I wish to discuss special arrangements for payments Interest of 2% per month on late payments will be charged automatically

CLINICAL EXAMINATION



MAIN COMPLAINT:

INITIAL RADIOGRAPHY EXAM

PAN _____ BW _____ FMX _____ PA _____

Bone Loss _____

Furcations _____

Apical Lesions _____

Impactions _____

Remarks _____

INITIAL PERIODONTAL EXAM

Inflammation	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	
Plaque	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Severe <input type="checkbox"/>	
Food Impaction	_____			
Calculus	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Heavy <input type="checkbox"/>	
	Supra <input type="checkbox"/>	Subgingival <input type="checkbox"/>		
Staining	Mild <input type="checkbox"/>	Moderate <input type="checkbox"/>	Heavy <input type="checkbox"/>	
Halitosis	_____			
Oral Hygiene	Poor <input type="checkbox"/>	Fair <input type="checkbox"/>	Good <input type="checkbox"/>	Excellent <input type="checkbox"/>
Flossing	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Smoking	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Attached Gingiva	Pink <input type="checkbox"/>	Red <input type="checkbox"/>	Blue <input type="checkbox"/>	
	Firm <input type="checkbox"/>	Swollen <input type="checkbox"/>	Receded <input type="checkbox"/>	
Attachment Loss	_____			

DIAGNOSIS

Gingivitis	Early <input type="checkbox"/>	Moderate <input type="checkbox"/>	Advanced <input type="checkbox"/>
Periodontitis	Early <input type="checkbox"/>	Moderate <input type="checkbox"/>	Advanced <input type="checkbox"/>
		Localized <input type="checkbox"/>	Generalized <input type="checkbox"/>

Remarks _____

INITIAL OCCLUSION

Molar Relation Left _____ Right _____

Cuspid Relation Left _____ Right _____

Overjet _____ Overbite _____ %

Crossbite _____

Habits: Thumb Tongue Mentalis

Remarks _____

INITIAL TMJ

Pain	No <input type="checkbox"/>	Left <input type="checkbox"/>	Right <input type="checkbox"/>
Popping	No <input type="checkbox"/>	Left <input type="checkbox"/>	Right <input type="checkbox"/>
Crepitus	No <input type="checkbox"/>	Left <input type="checkbox"/>	Right <input type="checkbox"/>
Maximum Opening	_____ mm		
Deviation on Closing	_____ Rmm	_____ Lmm	

INITIAL SOFT TISSUE EXAM

Tonsils _____	
Palate _____	
Tongue _____	
Throat _____	
Floor _____	
Lymph Nodes _____	
Buccal Mucosa _____	
Buccal Vestibule _____	
Attached Gingiva _____	
Remarks _____	

NEWTONBROOK DENTAL OFFICE

5857 Yonge Street

Willowdale, ON M2M 3T9

416-223-2453 or 416-229-9597

PERMISSION TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION

Our office understands the importance of protecting your personal information.

We will collect, use and disclose your personal information only for the appropriate purpose.

1. To diagnose and provide health care.
2. To communicate with you and your other health care professionals.
3. For scheduling and billing purposes, including completion of dental claim forms.
4. For teaching and demonstrating on an anonymous basis.
5. To comply with the legal requirements of the RCDS of Ontario, provincial regulations, and to generally comply with the law.
6. For audit and evaluation of the dental practice.
7. To provide an invoice, process credits or debit card payments, and to collect unpaid accounts.

If a new purpose would arise for the use and disclosure of your personal information, we will seek your approval in advance. We will not under and conditions supply your insurer with your confidential medical history, without your specific consent. If unusual requests are received, we will contact you for permission prior to releasing such information. You may withdraw your consent for us to disclose of your personal information, and we will explain the ramifications of that decision. In this office any Doctor may act as the Privacy Information Officer.

PATIENT CONSENT

I have reviewed the above information that explains how our office will use y personal information, and the steps taken to protect my information. I know that your office has a privacy code.

I agree that Newtonbrook Dental Office can collect, use and disclose personal information about _____ as set out in the above privacy policies.

Print
Name _____ Signature _____

Date _____ Witness _____

NEWTONBROOK Dental Office

Newtonbrook Plaza 5857 Yonge Street. Willowdale, On M2M 3T9

OFFICE POLICIES

Cancellation: The appointments are reserved time for you only. A minimum Notice of **48** hours is required to avoid the service charge of **\$50.00**

Initial...

Payments: Payment is required at the time of each appointment. Cash, Debit, Visa and MasterCard are accepted.

Initial...

Insurances: Payment is required at the time of each appointment. We take no responsibility with regards to your plan's coverage. In order to assist you with the processing of your claims, only with your request, we can prepare the necessary forms for your insurance company on your behalf.

Initial...

Privacy: NewtonBrook Dental Office reserves the right, according to the patient Privacy act, to withhold all patient information strictly confidential. Patient authorization/signature is required prior to the release of Any information to a third party.

Initial...

I have read and understood the policies listed above.

Name-----

Signature-----