NEWMARKET DENTAL CARE

"Taking Care of Tomorrows' Smile Today"

WELCOME TO OUR OFFICE

PATIENT REGISTRATION **ALL INFORMATION IS CONFIDENTIAL**

The following information is required by the dentist to assist in proper diagnosis and treatment. Please feel free to ask receptionist for help in completing this form. PLEASE PRINT.

Name: ______________________________ Date of birth ____________
(last) (first) (initial) (Day/Month/Year)

If child. Parent's Name: ______________________________
(last) (first)

Address: ______________________________
(street) (apt)

____
(city) (province) (postal code) e-mail

Home Phone: ____________ Cell Phone: ____________ Business Phone: ____________

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

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household).

Name: ____________ Relationship: ____________

Home Phone: ____________ Cell Phone: ____________ Business Phone: ____________

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Name of Subscriber		Date of Birth (DD/MM/YY)
Employer/Group Policy holder		Insurance Year End
Insurance Company		Phone
Group/Individual Policy No.	Certificate No.	
I.D./S.I.N.	Maximum Coverage	
Percentage Coverage		
Basic	Major Res	Perio
Electronic Submission Approval I hereby authorize the release of information contained in claims to be submitted electronically to my insuring plans administrator.		
Subscriber Signature		Date
Payment Assignment Approval I hereby assign my dental benefits payable to the named dentists and authorize payment directly to him/her.		
Subscriber Signature		Date

SECONDARY DENTAL INSURANCE

Name of Subscriber		Date of Birth (DD/MM/YY)
Employer/Group Policy holder		Insurance Year End
Insurance Company		Phone
Group/Individual Policy No.	Certificate No.	
I.D./S.I.N.	Maximum Coverage	
Percentage Coverage		
Basic	Major Res	Perio
Electronic Submission Approval I hereby authorize the release of information contained in claims to be submitted electronically to my insuring plans administrator.		
Subscriber Signature		Date
Payment Assignment Approval I hereby assign my dental benefits payable to the named dentists and authorize payment directly to him/her.		
Subscriber Signature		Date

DENTAL HISTORY

Reason for Today's Visit ____________ Date of last dental care ____________

Former Dentist ____________ Date of last x-rays ____________

Address ____________

Place a "check" ☑ mark if you have had any of the following:

- ❑ Bad Breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

How often do you floss? ____________ How often do you brush? ____________

Please Turn Over

Health History

Physician's Name: ______________________ Date of last visit ______________

Place a "check" ☑ mark if you have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart with Congenital Lesions
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Problems
- ☐ Heart with Artificial Valves
- ☐ Heart with Mitral Valve Prolapse
- ☐ Heart Stroke
- ☐ Hepatitis Type ________
- ☐ Herpes
- ☐ High/Low Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Problems
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sleep apnea
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Swelling of Feet or Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weigh Loss, unexplained

Any recent surgery? If yes, please explain. ______________________

Any medical conditions we should be aware of not listed above? If yes, please explain. ______________________

Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Due Date:______________

Are you nursing? ☐ Yes ☐ No

Medications	Allergies	
List medications you are currently taking	Place a "check" ☑ mark if you have had any allergies to the following:	
	☐ Aspirin	☐ Local Anesthetic
	☐ Barbiturates (sleeping pills)	☐ Penicillin
	☐ Codeine	☐ Sulfa
	☐ Iodine	☐ Other ______________
	☐ Latex	

OFFICE POLICY

Your appointment time will be reserved specially for you. If you are unable to keep the appointment, we will require *2 working days notice*, otherwise it may be necessary to charge for time lost.

PATIENT CONSENT/GENERAL RELEASE

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as may be necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services provided to my dependants or me

.Patient (Parent, Guardian) Signature ______________________

If parent/guardian*, please print name ______________________ Date ________

*Guardian of child or guardian of adult under guardianship

Please Turn Over