Welcome To Our Dental Family

Duffins Creek Dental

PID: _____ **SCAN:** ☐

Personal Information (Confidential)

To help us meet your dental health care needs, Please fill out this form completely

☐Mr. ☐Mrs. ☐Miss. ☐Ms. ☐Dr. ☐Male ☐Female

Name: _____
(Last Name) (First Name) (Initial)

Preferred Name: _____ Date of Birth: ___/___/___
DD/MM/YYYY

Address: _____
(Street) (Apt#)

_____
(City) (Province) (Postal Code)

Phone: Home: ( ) - Work: ( ) - X

Cell: ( ) - Other: ( ) -

Email: _____ Are you available on short notice for appointments:? ☐Yes ☐No

Best way to contact: ☐Home ☐Cell ☐Work ☐Other ☐Email ☐Text

Best time to call: ☐Any time ☐Morning ☐Afternoon ☐Evening

Employer/School: _____ Occupation: _____

Family Physician: _____ Phone No: ( ) -

In Case of Emergency: _____ ( ) -
Notify Name Relationship Phone No.

Are You Familiar with Your Dental Plan details? ☐Yes ☐No

Responsibile Party (If patient is a child/dependent adult responsible for account)

Name: _____ DOB: ___/___/___
(Last Name) (First Name) (Initial) DD/MM/YYYY

Address: _____
(Street) (Apt#) (City) (Province) (Postal Code)

Phone: Home: ( ) - Work: ( ) - X

Primary Insurance

Subscriber: _____ DOB: ___/___/___
INSURANCE HOLDER NAME DD/MM/YYYY

Relation: ☐Self ☐Spouse ☐Child ☐Other _____

Insurance Co: _____ Phone No: ( ) -

Certificate / ID # _____ Policy / Plan / Group # _____ Division / Sect: ___

Secondary Insurance

Subscriber: _____ DOB: ___/___/___
INSURANCE HOLDER NAME DD/MM/YYYY

Relation: ☐Self ☐Spouse ☐Child ☐Other _____

Insurance Co: _____ Phone No: ( ) -

Certificate / ID # _____ Policy / Plan / Group # _____ Division / Sect: ___

Referral Information (How did you Hear About Us?)

☐Another Patient ☐Friend ☐Relative ☐Professional ☐Staff Member: _____

☐Internet ☐Google ☐Social Media ☐Website ☐Walk-In ☐Other: _____

Medical History — All information is confidential

The following information is required by the dentist to assist in proper diagnosis and treatment

1. Have you ever had a serious illness, requiring hospitalization in the past five years or extensive medical care? ☐Yes ☐No
   Please Specify: _____
2. Are you presently under the care of a physician? Please Specify: _____ ☐Yes ☐No
3. Do you take any prescription or non prescription drugs regularly? Please Specify: _____ ☐Yes ☐No
4. Do you have any known Allergies? Please Specify: _____ ☐Yes ☐No
5. Do any allergic reactions result in headaches, shortness of breath, chest constrictions, nausea, skin rashes? ☐Yes ☐No
   Please Specify: _____
6. Have you ever experienced any unusual reaction to any of the following ☐Yes ☐No
   ☐ Local Anaesthesia (freezing) ☐ aspirin ☐ penicillin ☐ codeine ☐ sulpha drugs ☐ barbiturates (sleeping pills) ☐ Any other medicine
   Please explain: _____
7. Have you been cautioned against taking any drug or medication? if Yes, Please Specify: _____ ☐Yes ☐No
8. Do you have, or have had, any of the following? Please check any that apply. ☐Yes ☐No

☐Heart Murmur or Mitral valve Prolapse	☐Malignant Hyperthermia	☐Joint Replacement	☐Diabetes	☐Stroke	☐Liver Disease
☐Stomach/Intestinal Problems/Ulcers	☐Drug/Alcohol Dependency	☐Kidney Problems	☐Herpes	☐Hepatitis AIB/C	☐Emphysema
☐Mental or Nervous Disorder	☐Arthritis or Rheumatism	☐Cold Sores	☐Jaundice	☐Lung Disease	☐Sinus Trouble
☐High/Low Blood Pressure	☐Scarlet or Rheumatic Fever	☐Tuberculosis	☐AIDS/HIV	☐Thyroid Disease	☐Glaucoma
☐Hyper/Hypo Glycemia	☐Cortisone/Steroid Therapy	☐Epilepsy or Seizures	☐Heart Attack	☐Cancer/Chemotherapy	☐Fainted Ever
☐Organ Implants or Medical Implants	☐Experience Shortness of Breath or Chest Pain when walking or climbing stairs			☐Bruise Easily or Bleed Abdnormally	

9. Have you had any injury, surgery or x-ray therapy to your face or jaws? ☐Yes ☐No
10. Do you have any medical condition or concerns that the doctor should know about? Please Specify: _____ ☐Yes ☐No
11. Women: Are you pregnant? ☐Yes ☐No Are you Nursing? ☐Yes ☐No Are you taking birth control pills? ☐Yes ☐No

Dental History

1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Dental Emercency ☐ Dental Pain ☐ Other: _____
2. Is there a dental problem you would like to take care of as soon as possible? Please Specify: _____ ☐Yes ☐No
3. How frequently do you visit your dentist? ☐ 3-6 Months ☐ 6-9 Months ☐ Annually ☐ Other: _____
4. When was your last dental cleaning? _____
5. How often do you brush your teeth? _____ Floss? _____
6. Does your jaw crack or pop when open widely/eating? Please Specify: _____ ☐Yes ☐No
7. Do you have the any of the following? Please check any that apply.

☐ Braces	☐ Oral Surgery	☐ Gum Treatment	☐ Root Canal
☐ Bad Breath	☐ Bleeding Gum	☐ Jaw Pain/Migraine Headache	☐ Loose or Broken Teeth
☐ Loose or Broken Fillings	☐ Grinding Teeth	☐ Sores or Growth in the Mouth	☐ Missing Teeth
☐ Gum Recession	☐ Gum Swollen/Tender	☐ Teeth Feel Rough	☐ Teeth Stain

8. Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Biting ☐ Sweets
9. Do you smoke? Number per day: _____ For, how long have you been smoking? _____ ☐Yes ☐No
10. Are you nervous about dental appoinments? ☐Yes ☐No
11. Have you ever experienced complications during dental treatments? Please Specify: _____ ☐Yes ☐No
12. Would you like to learn about dental implants to replace missing teeth? ☐Yes ☐No
13. Have you ever received oral hygiene instruction? ☐Yes ☐No

GENERAL RELEASE/CONSENT

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependants is mine, and I will assume responsibility for fees associated with these services at the end of each appointment.

Signature ☐ Self ☐ Parent ☐ Guardian For _____

Print Name _____ Signature _____

Date _____ DD _____ MM _____ YYYY Reviewing Doctor _____

Thank You