WELCOME TO OUR DENTAL OFFICE

PATIENT INFORMATION:

NAME: Mr./Miss/Mrs./Ms./Dr. ____

DATE OF BIRTH (DAY/MONTH/YEAR):____

HEALTH CARD NUMBER: ____

ADDRESS: ____

____

HOME NUMBER: ______________________ CELL PHONE: ______________________

E-MAIL ADDRESS: ____

OCCUPATION:____

FAMILY PHYSICIAN: ______________________ FORMER DENTIST: ______________________

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:____

RELATIONSHIP: ______________________ DAY-TIME PHONE NUMBER: ______________________

HOW DID YOU HEAR ABOUT US? □ Online □ Location □ Friend/Family ______________________

INSURANCE INFORMATION:

Name of Policy Holder	Date of Birth	Relationship to Policy Holder
Name of Employer	Group/Policy #	Certificate/ID #
Insurance Company	Insurance Co. Phone #	

Secondary Insurance (if applicable):

Name of Policy Holder	Date of Birth	Relationship to Policy Holder
Name of Employer	Group/Policy #	Certificate/ID #
Insurance Company	Insurance Co. Phone #	

By signing this statement, you authorize Limeridge Mall Dental to complete any necessary insurance claim forms on your behalf. You are hereby also authorizing the release of any medical or other information which may be needed in order to process your dental claims with your specific insurance company.

Our professional services are rendered to you, not your insurance company. Patients are directly responsible for payment of their treatment, and then you will be variably reimbursed by your insurance company, unless an alternative financial agreement has been arranged.

PATIENT NAME: ______________________ SIGNATURE:______________________

(Legal guardian if under 18)

DATE: ______________________

Continue →

CONFIDENTIAL MEDICAL HISTORY:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the document and explain any questions you do not understand.

1. When was your last medical checkup? ________________________________
2. Are you being treated for any medical condition at present, or have you been treated within the past year? □ YES □ NO

   Please specify____
3. Has there been any change to your general health in the past year? □ YES □ NO

   If yes, please explain____
4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. □ YES □ NO

   ____________________________________ ___________________________________ ____________________________________

   ____________________________________ ___________________________________ ____________________________________
5. Do you have any allergies? Please include medications (e.g. penicillin, sulfa), other (e.g. latex, foods) □ YES □ NO

   Please specify____
6. Have you ever had an adverse reaction to any medications or injections? □ YES □ NO

   If yes, please explain____
7. Do you have, or have you ever had asthma? ____ □ YES □ NO
8. Do you have, or have you ever had any heart or blood pressure problems? ________________________________ □ YES □ NO
9. Do you have, or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?______________ □ YES □ NO
10. Do you have a prosthetic or artificial joint? □ YES □ NO Details: ____
11. Do you have any conditions or therapies that could affect your immune system? i.e. leukemia, AIDS, HIV infection, radiation, chemotherapy? ____□ YES □ NO
12. Have you ever had hepatitis, jaundice or liver disease? ____ □ YES □ NO
13. Do you have a bleeding problem or bleeding disorder? ____ □ YES □ NO
14. Have you ever been hospitalized for any illnesses or operations? ____ □ YES □ NO

    If yes, please explain____
15. Do you have, or have you ever had any of the following? Please check.

□ Chest Pain, Angina	□ Stroke	□ Rheumatic Fever	□ Steroid Therapy	□ Seizures (Epilepsy)
□ Heart Attack	□ Lung Disease	□ Heart Murmur	□ Stomach Ulcers	□ Arthritis
□ Mitral Valve Prolapse	□ Shortness of Breath	□ Cancer	□ Thyroid Disease	□ Kidney Disease
□ Pacemaker	□ Tuberculosis	□ Diabetes	□ Osteoporosis	□ Drug/Alcohol Dependency

Other: ____

16. Are there any diseases or medical conditions that run in your family? (e.g. diabetes, cancer, heart disease) □ YES □ NO

    If yes, please specify ____
17. Do you smoke or chew tobacco products? □ YES □ NO Amount ______________________________
18. **For women only:** Are you breastfeeding or pregnant? □ YES □ NO If pregnant, expected delivery date _________________

Continue →

DENTAL HISTORY:

1. When was your last dental visit? ____
2. Are you having any discomfort at this time? □ YES □ NO ____
3. Have you ever had any complication with local (freezing) or general anesthetic? □ YES □ NO
4. Are you aware of any lump or swelling in your mouth? □ YES □ NO
5. Are you satisfied with the appearance of your teeth? □ YES □ NO
6. Are you anxious about dental treatment? □ YES □ NO
7. Do you currently experience any of the following? Please check.

□ Loose Teeth □ Bleeding Gums □ Sensitive Teeth □ Bad Breath □ Unsatisfactory Dentures

□ Missing Teeth □ Gagging □ Headache □ Popping or Clicking in the Jaw Joints

To the best of my knowledge, I have provided an accurate and complete personal, medical and dental history.

PATIENT NAME: ____ SIGNATURE: ___________________________________

(Legal guardian if under 18)

DATE: ____

OFFICE POLICY:

At Limeridge Mall Dental, we value our patient's time and make every effort to remain on schedule. To ensure that we deliver the best dental care in a timely manner, we do expect your cooperation.

When you schedule an appointment, an operatory has been reserved especially for you. A **courtesy** confirmation call is extended to you. With this in mind, we do require two business days notice to make any change in your reserved appointment time.

Without two business days notice, a $25.00 appointment fee will be charged. Additional missed appointment fees will be charged at the discretion of your dentist. Insurance plans do not cover these charges.

I have read the missed appointment protocol above. I understand and agree to the above protocol.

PATIENT NAME: ____ SIGNATURE: ___________________________________

(Legal guardian if under 18)

DATE: ____