Welcome to our office

Please complete the following confidential information:

PERSONAL INFORMATION

Date:_____
Surname: Mr/Mrs/Ms/Miss/Dr_____Given Name:_____
Telephone: Home:_____ Work:_____Cell:_____
Address_____
City:_____Province:_____Postal Code:_____
Date of Birth: Day_____Month_____Year_____
Person responsible for account:_____

DENTAL INSURANCE INFORMATION

Do you have dental insurance coverage? ***Yes No*** If Yes, fill out the following
Insurance Company_____ Date employed _____
Employer_____ Name of insured _____
ID#_____Group#_____Certificate#_____
Div_____SIN_____
Coverage(%) A_____ B_____ C_____
Limits/ Deductibles_____

Are you covered under a second dental plan? ***Yes No*** If Yes, fill out the following
Insurance Company_____ Date employed _____
Employer_____ Name of insured _____
ID#_____Group#_____Certificate#_____
Div_____SIN_____
Coverage(%) A_____ B_____ C_____
Limits/ Deductibles_____

NOTE: Please be aware of any limitations to your plan since responsibility for your account belongs to you. Our staff will gladly handle your insurance details.

Who may we thank for referring you? _____

DENTAL QUESTIONNAIRE

1. Are you in pain or discomfort? ***Yes No*** _____

2. What are your reasons for visiting our dental clinic? _____

_____

3. Please provide the approximate date of your last dental check-up_____

4. Are you satisfied with your teeth?

Chewing	***Yes No***
Speech	***Yes No***
Aesthetics *(How your teeth look)*	***Yes No***

5. Do you experience any of the following problems (please check)?

- ❑ Swelling, sores or lumps in the mouth
- ❑ Sensitive teeth
- ❑ Bleeding gums
- ❑ Loose tooth/teeth
- ❑ Grinding or clenching habits
- ❑ Frequent headaches
- ❑ Clicking or popping noises from jaw joints
- ❑ Tension or pain from headaches, neck or shoulders
- ❑ Ringing in the ears
- ❑ Balance problems

6. Are you currently being treated by a physiotherapist or chiropractor for any neck, shoulder or spinal problems? ***Yes No***

7. Have you ever had any of the following treatments (please check)?

- ❑ Bridges or crowns
- ❑ Partial dentures
- ❑ Extractions
- ❑ Periodontal (gum) treatments
- ❑ Orthodontics
- ❑ Complete dentures
- ❑ Surgery in the mouth
- ❑ Root canal fillings

8. Have you ever had a traumatic experience in a dental office? ***Yes No***

9. Does any type of dental treatment make you feel nervous, anxious or nauseous?

PATIENT CONSENT:
I, the undersigned hereby consent to take X-rays, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I consent to the dental treatment agreed upon and also understand the use of anesthetic agents embodies a certain risk. I understand that a possibility of complication exists for each treatment. I understand that responsibility for payment for dental services rendered in this office is expected at the end of each appointment unless other financial arrangements have been made. Furthermore, I authorize release of information from my dental plan administrator and consent to electronic submission of my dental claims.

*Signature*_____ *Date*_____

*Signature of parent or guardian (if under 18)*_____