Cataraqui Dental Centre

In an effort to serve you better, we would ask that you complete the following.
We will be glad to assist you. PLEASE PRINT.

Patient Information

A parent or guardian will be responsible for decisions on my treatment. □ yes □ No

Name: Mr./Mrs. Ms._____
Miss/Dr. Last First Middle

Address. _____
Street Apt. City Prov. Postal Code

Home Tel: (___) _____ Work Tel: (___) _____ cell: (_____) _____

Best phone Number to contact you at: _____

E mail address: _____ Date of Birth: _____/_____/_____ Gender: M F
day month year

Employed by: _____ Occupation: _____

Emergency contact: _____ Tel: (___) _____

Family Physician: _____ Tel: (___) _____

Health Card Number: (OHIP Number) _____

How did you hear about our office? □ radio □ television □ friend / family member □ location □other_____

Are there other members of your family in this practice? □Yes □ No Who? _____

Financial Information

Person responsible for financial matters: □ Self □ Spouse □ Parent/Guardian □ Other
(If different from above)
Name: _____

Address: _____

I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures. Office policy is that services are paid for at each visit as they are performed. Insurance is the responsibility of the patient, should you require any assistance, our office staff will be glad to assist you.
If you are unable to keep the appointment we require 2 business days notice, otherwise it will be necessary to charge for the time lost.

Dental History:

1. What is the reason for today's visit? □ New patient examination □ Emergency
2. ARE YOU IN DISCOMFORT AT THIS TIME? □Yes □No
3. When was your last dental visit? _____
4. Who was your previous dentist? _____
5. How frequently do you see a dentist? □ 3-6 mos. □ 9-12 mos. □ Other _____
6. Are your teeth sensitive to: □ Cold □ Sweet □ Heat □ Other _____
7. Do your gums bleed when: □ Brushing □ Flossing □ Other _____

		Yes	No	Maybe
8.	Do your gums feel swollen or tender?	□	□	□
9.	Do you have bad breath or a bad taste in your mouth?	□	□	□
10.	Does your jaw crack or pop when you open widely?	□	□	□
11.	Do you grind or clench your teeth?	□	□	□
12.	HAVE YOU EVER HAD LOCAL ANAESTHETIC (FREEZING)? ANY COMPLICATIONS? □ Yes □No Specify _____	□	□	□
13.	Have you had any problems with previous dental treatment Specify _____	□	□	□
14.	Are you satisfied with your teeth? Specify _____	□	□	□
15.	Do you snore?	□	□	□
16.	Has anyone ever told you that you have stopped breathing while sleeping	□	□	□

MEDICAL HISTORY (This information will remain confidential)

Have you ever experienced a SENSITIVITY to LATEX? ☐ Yes ☐ No
Are you ALLERGIC to LATEX? ☐ Yes ☐ No
Is any member of your family ALLERGIC to LATEX? ☐ Yes ☐ No

1. Have you ever been hospitalized? Explain_____ ☐ Yes ☐ No
2. Are you taking any prescription, non-prescription or any other drugs at this time ☐ Yes ☐ No

A) Drug _____ Reason _____
B) Drug _____ Reason _____
C) Drug _____ Reason_____
D) Drug _____ Reason_____
E) Drug_____ Reason_____
F) Drug_____ Reason_____

3. **ARE YOU ALLERGIC TO ANY MEDICATIONS?**
☐ PENICILLIN ☐ CODEINE ☐ ASPIRIN ☐ LOCAL ANAESTHETIC (FREEZING) ☐ OTHER ☐ NONE

Describe _____

4. Have you ever had JOINT REPLACEMENT SURGERY? When (date)_____ ☐ Yes ☐ No
5. Have you ever been told you have a HEART MURMUR? ☐ Yes ☐ No
6. Have you ever been told you need to take antibiotics prior to dental treatment? ☐ Yes ☐ No
7. Do you have prolonged bleeding or bruise easily? ☐ Yes ☐ No
8. Do you smoke? ☐ Yes ☐ No How much? _____
9. Are you presently under the care of a physician ? ☐ Yes ☐ No
Explain_____
10. Are you pregnant? ☐ Yes ☐ No Using birth control? ☐ Yes ☐ No

11. Do you have or have you had any of the following? Please check appropriate boxes.

☐ Aids	☐ Epilepsy	☐ Leukemia
☐ Anaemia	☐ Diabetes	☐ Lung disease
☐ Angina pectoris	☐ Glaucoma	☐ Malignant hyperthermia
☐ Anorexia nervosa	☐ Head/neck injuries	☐ Mental/nervous disorders
☐ Artificial heart valve	☐ Heart disease/attack	☐ Mitral valve prolapse
☐ Arthritis/rheumatism	☐ Organ transplant/implant	☐ Heart pacemaker/surgery
☐ Psychiatric disorders	☐ Asthma	☐ Heart rhythm disorder
☐ Radiation/Chemotherapy	☐ Blood disorders	☐ Hepatitis A/B/C
☐ Rheumatic/Scarlet fever	☐ Bronchitis	☐ Herpes
☐ Sickle Cell disease	☐ Bulimia	☐ High/Low blood pressure
☐ Sinus trouble	☐ Cancer	☐ HIV positive
☐ Stomach/intestinal problems	☐ Circulation problems	☐ Hodgkin's disease
☐ Stroke	☐ Congenital heart lesions	☐ Hyper(Hypo) glycemia
☐ Thyroid disease	☐ Cortisone/steroid	☐ Hypertension
☐ Tuberculosis	☐ Drug /alcohol dependence	☐ Kidney disease
☐ Ulcers	☐ Emphysema	☐ Liver disease
☐ STD	☐ Glandular disorders	☐ Other_____ ☐ None

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. Ontario has a law that protects personal health information. The Cataraqui Dental Centre maintains a strict privacy policy. (For more information please ask to see the Cataraqui Dental Privacy Policy) I agree that the Cataraqui Dental Centre can collect, use and disclose personal information in accordance with the privacy legislation set forth by the Province of Ontario.

I give The Cataraqui Dental Centre permission to electronically submit any claims or estimates to my insurance company on my behalf.

_____ _____ _____
Signature ☐ Patient ☐ Parent/Guardian Print name Date

WE WELCOME NEW PATIENTS

www.cataraquidental.com
Email: info@cataraquidental.com