NORTH TORONTO DENTAL CENTRE

Patient Information Form

The information in this questionnaire is CONFIDENTIAL and enables our office to provide the highest level of care and service possible. Please complete all forms as completely as possible. Thank you.

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ (DD/MM/YY) ☐ Male ☐ Female

Address: _____ Apt/Unit #: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Marital Status: ☐ Single ☐ Married/Common Law ☐ Other

Employer: _____ Position: _____

May we contact you at your workplace? ☐ Yes ☐ No Work Number: _____

May we contact you on your cell phone? ☐ Yes ☐ No Cell Number: _____

May we contact you by email? ☐ Yes ☐ No Email address: _____

X I consent to receive emails from NTDC in regards to financing, appointments and marketing. Initial: _____

In case of an emergency please notify: _____ Phone number: _____

Best way to contact you? ☐ Home ☐ Work ☐ Cell Email Best time to contact you? ☐ Morning ☐ Afternoon ☐ Evening

INSURANCE INFORMATION

Primary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)

Insurance Policy Holder: ☐ Self ☐ Parent/Guardian ☐ Other _____

Policy Holder Phone Number (if different from above): _____ Employer: _____

Insurance Company Name: _____ Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Secondary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)

Insurance Policy Holder: ☐ Self ☐ Parent/Guardian ☐ Other _____

Policy Holder Phone Number (if different from above): _____ Employer: _____

Insurance Company Name: _____ Group Policy/Plan Number: _____ I.D./Certificate Number: _____

REFERRAL INFORMATION

How did you hear about us? (Check all that apply)

☐ Internet — Website/search engine source: _____

☐ Flyer — flyer description: _____

☐ Newspaper — newspaper name(s): _____

☐ Word of Mouth — name of person: _____

☐ Walked By ☐ Other — please specify: _____

DENTAL HISTORY

Please share the following dates:

Date of last dental visit: _____ Date of last dental cleaning: _____

Date of last dental x-rays:_____ Your last oral cancer screening: _____

Do you smoke or use chewing tobacco? ☐ Yes ☐ No

If yes, how often? _____For how long? _____

Please check any of the following problems that may apply to you:

- ☐ Sensitivity (hot, cold and/or sweet)
- ☐ Tooth pain or discomfort while chewing
- ☐ Bleeding teeth or fillings
- ☐ Broken teeth or fillings
- ☐ Loose, tipped or shifting teeth
- ☐ Headaches, earaches or neck pain
- ☐ Grinding or clenching teeth
- ☐ Jaw joint pain (clicking/cracking)
- ☐ Bad breath or bad taste in your mouth
- ☐ Sore spots/growths

Do you have or have you ever had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Difficult extractions
- ☐ Braces
- ☐ Periodontal (gum) treatments

If you could change your smile, you would...

- ☐ Make your teeth brighter
- ☐ Make your teeth straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with natural, tooth coloured fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

What is the name of your previous dentist?

_____

Why did you leave your previous dentist?

_____

What if anything, in the past has kept you from having dental treatment?

_____

What is the most important thing to you about your future smile and dental health?

_____

MEDICAL HISTORY

Please check any of the following that apply to you:

- ☐ AIDS
- ☐ Allergies, seasonal
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valve
- ☐ Artificial joints
- ☐ Asthma
- ☐ Blood disease
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug addiction
- ☐ Emphysema
- ☐ Excessive bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart conditions
- ☐ Heart lesions, congenital
- ☐ Heart murmur
- ☐ Heart surgery
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High blood pressure
- ☐ HIV positive
- ☐ HPV
- ☐ Jaundice
- ☐ Jaw joint pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Phen fen (1 month+)
- ☐ Pregnant currently
- ☐ Radiation (head/neck)
- ☐ Respiratory problems
- ☐ Rheumatic fever
- ☐ Rheumatism
- ☐ Scarlet fever
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stomach problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal diseases
- ☐ Other _____

Do you have any of the following allergies?

- ☐ Penicillin
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Local anaesthetic
- ☐ Percocet
- ☐ Sulpha
- ☐ Erythromycin
- ☐ Other_____
- ☐ Nitrous oxide
- ☐ Valium

Have you ever had a joint replacement? ☐ Yes ☐ No If yes, when? _____

Has your physician ever told you to take antibiotics prior to dental procedures? ☐ Yes ☐ No

If so, why? _____

Have you ever experienced complications following a medical or dental procedure? ☐ Yes ☐ No

If yes, please describe: _____

Is there anything else you think we should know regarding your medical history? ☐ Yes ☐ No

If yes, please describe: _____

Are you currently under a physician's care? ☐ Yes ☐ No If yes, what for? _____

Are you taking any medications? ☐ Yes ☐ No If yes, please specify: _____

Family Physician's Name: _____ Phone Number: _____

PRIVACY INFORMATION

I certify that I have read, understood and accurately completed the personal, medical, and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. If required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided.

Consent for Collection, Use and Disclosure of Personal Information

I agree that North Toronto Dental Centre has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

Date: _____ Signature: _____