NORTH WOODSTOCK DENTISTRY

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Personal Information

Surname_____ First_____ Date of Birth (DD/MM/YYYY)_____ Gender: M ☐ F ☐

Address_____ City_____ Postal Code_____

Occupation_____ Employer_____ Address_____

Phone (Res)_____ Phone (Bus)_____ Phone (Cell)_____

Email_____

Family Physician_____ Phone (Bus)_____

Date of Last Exam (DD/MM/YYYY)_____ Marital Status:_____ Health Card #_____

Name of Spouse, Parent, or Guardian_____

Occupation_____ Employer_____ Address_____

Phone (Res)_____ Phone (Bus)_____

Emergency Contact_____ Relationship_____ Phone_____

Whom may we thank for referring you to our practice?

☐ Another Patient_____ ☐ Doctor_____

☐ Staff_____ ☐ Online/Social_____

☐ Advertisement ☐ Magazine ☐ TV ☐ Newspaper ☐ Radio ☐ Other_____

Insurance Information

Do you have dental insurance? Yes ☐ No ☐

Name of Insured_____ Insured Date of Birth (DD/MM/YYYY)_____

Insurance Company_____ Group #_____ ID #_____

Driver's License #_____

This information is collected to verify identity and settle any account balances not covered by insurance.

Secondary Insurance Information

Do you have dental insurance? Yes ☐ No ☐

Name of Insured_____ Insured Date of Birth (DD/MM/YYYY)_____

Insurance Company_____ Group #_____ ID #_____

Driver's License #_____

This information is collected to verify identity and settle any account balances not covered by insurance.

See other side.

Health Information

Do any of the following apply to you?

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cannabis Use
- ☐ Cigarette Smoking
- ☐ Codeine/Penicillin Allergy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy/Convulsions
- ☐ Excessive Bleeding
- ☐ Fainting Seizures
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Attack
- ☐ Heart Murmur F/O
- ☐ Heart Problems
- ☐ Hepatitis: A B C (circle)
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorder
- ☐ Pacemaker
- ☐ Pregnancy Due_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Surgery_____
- ☐ Thyroid Problem
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other: _____

- ☐ Complications after dental treatment
- ☐ Need for admission to a Hospital/Emergency
- ☐ Under the care of a physician
- ☐ Any health concerns

_____

_____

Dental Information

Please check those that apply:

- ☐ Bad Breath
- ☐ Bad Experience
- ☐ Bleeding Gums
- ☐ Blisters in Mouth
- ☐ Burning Sensation
- ☐ Chewing on One Side
- ☐ Clicking Jaw
- ☐ Crowns/Bridges
- ☐ Dry Mouth
- ☐ Extractions
- ☐ Fillings
- ☐ Fingernail Biting
- ☐ Food Trapped in Teeth
- ☐ Foreign Objects
- ☐ Grinding Teeth
- ☐ Gums Swollen/Bleeding
- ☐ Jaw Pain
- ☐ Lip/Cheek Biting
- ☐ Local Anaesthetic Reaction
- ☐ Loose/Broken Teeth
- ☐ Mouth Breathing
- ☐ Mouth Pain
- ☐ Orthodontic Treatment
- ☐ Pain Around Ear
- ☐ Periodontal Treatment
- ☐ Removable Denture
- ☐ Root Canal Therapy
- ☐ Strong Gag Reflex
- ☐ Sensitivity to Biting
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Sweets
- ☐ Sores/Growths in Mouth
- ☐ Syncope (Fainting)

- ☐ Any other conditions

Reason for today's visit: _____

Former Dentist: _____ City: _____ Prov: _____

Date of last dental visit: _____ Date of last dental x-rays: _____

How often do you brush: _____ Floss: _____

Medication

List of medications you are currently taking:

_____ _____ Pharmacy name: _____

_____ _____ City/Prov: _____

_____ _____ Phone: _____

Authorization

I, the undersigned patient, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information.

I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated.

Unless other arrangements are made, payment is due at each office visit. My dental insurance is a contract between myself and the insurance company, not between the dentist and myself.

I will assume full responsibility for the fees associated with these procedures.

I am aware that 2-business days notice is required to change or cancel an appointment without charge.

I agree that North Woodstock Dentistry can collect, use and disclose personal information about myself or my dependents as set out in the office's privacy policies, and consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. I further agree to receive electronic messages, including text messages, in regards to communicating appointments, requests, information, products, promotions, company news and updates which can be withdrawn at any time. I further consent to being videotaped in public areas of the dental office.

_____ _____ _____

Patient/Guardian Signature | Dentist Signature | Date