

# WELCOME to west 17th avenue dental care

WWW.SOUTHWESTDENTIST.COM

*We are pleased to welcome you to our clinic!*

*Please take a few minutes to fill out this form as completely as you can.*

*If you have questions, we'll be glad to help you. Thank you.*



## PATIENT INFORMATION

NAME \_\_\_\_\_ GENDER  M  F  
Last First Initial "preferred name"

BIRTHDATE \_\_\_\_\_ SIN # \_\_\_\_\_  Single  Married  Child  Other  
dd / mm / yyyy

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_  
POSTAL CODE \_\_\_\_\_

PHONE (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Ext: \_\_\_\_\_  
(Cell) \_\_\_\_\_ (Fax) \_\_\_\_\_

EMAIL \_\_\_\_\_ EMPLOYER \_\_\_\_\_

BEST TIME / METHOD TO CONTACT YOU \_\_\_\_\_

### HOW DID YOU HEAR ABOUT OUR OFFICE?

YELLOW PAGES \_\_\_\_ NEIGHBOURHOOD MAIL \_\_\_\_ EXTERIOR SIGN \_\_\_\_

ANOTHER PATIENT \*name \_\_\_\_\_ OTHER \_\_\_\_\_



Have you visited our website recently? Y \_\_\_\_ N \_\_\_\_



## DENTAL INSURANCE (if applicable)

**PLEASE FORWARD YOUR INSURANCE WALLET CARD(S) / INFORMATION  
TO THE FRONT DESK BEFORE YOUR APPOINTMENT BEGINS.**

This ensures we submit the correct information to your insurance provider.  
Most submissions can be completed "on-line", thus speeding up your reimbursement.  
This will be done on your behalf (and with your permission) at the completion of your appointment.

**IF THE PRIMARY POLICY HOLDER IS NOT YOURSELF** please indicate the information below:

NAME OF POLICY HOLDER & THEIR EMPLOYER \_\_\_\_\_

YOUR RELATIONSHIP TO POLICY HOLDER \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
dd / mm / yy

**YOUR DENTAL HISTORY**



What would you like us to do today? \_\_\_\_\_

- Are you in dental discomfort today?  Y  N If yes, when did it start? \_\_\_\_\_
- Approx. date of last dental care \_\_\_\_\_

**Have you ever had an unpleasant dental experience? (or any complications following treatment)**

please explain \_\_\_\_\_

**\*\*PLEASE INFORM A TEAM MEMBER IF THERE IS ANYTHING WE CAN DO TO MAKE YOUR VISIT MORE COMFORTABLE\*\***

**Check (✓) if you have had problems with any of the following:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> BAD BREATH                     | <input type="checkbox"/> FOOD COLLECTION BETWEEN TEETH | <input type="checkbox"/> CLICKING OR POPPING JAW |
| <input type="checkbox"/> BLEEDING GUMS                  | <input type="checkbox"/> GRINDING OR CLENCHING TEETH   | <input type="checkbox"/> ORTHODONTIC TREATMENT   |
| <input type="checkbox"/> LOOSE TEETH OR BROKEN FILLINGS |  |  |



**YOUR MEDICAL HISTORY**

**GENERAL PHYSICIAN'S NAME** \_\_\_\_\_ **PH. NUMBER / not nec.** \_\_\_\_\_

**APPROX. DATE OF LAST EXAM if applic.** \_\_\_\_\_

**Are you now under the care of a physician?**  Y  N If YES, please explain \_\_\_\_\_

**Have you been admitted to a hospital, or needed emergency care during the past 2 years?**  Y  N

If YES, please explain \_\_\_\_\_

**Check (✓) if you are ALLERGIC to, or have had any reaction to the following**

**Please LIST ALL MEDICATIONS you are currently taking (including NON-PRESCRIPTION)**

- |  |   |
|--|---|
| <input type="checkbox"/> Local Anesthetic                      | <input type="checkbox"/> Any metals (nickel, mercury, etc.) |
| <input type="checkbox"/> Penicillin (or any other antibiotics) | <input type="checkbox"/> Latex rubber                       |
| <input type="checkbox"/> Sulfa Drugs                           | <input type="checkbox"/> Sedatives                          |
| <input type="checkbox"/> Codeine                               | <input type="checkbox"/> Aspirin                            |

Other (please list) \_\_\_\_\_

**Do you use tobacco?**  frequency? \_\_\_\_\_

**Do you use illegal / controlled substances?**  frequency? \_\_\_\_\_

**Check (✓) if you have / had any of the following**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure <b>MEDICATED Y/N</b>        | <input type="checkbox"/> Low Blood Pressure        | <input type="checkbox"/> Headaches                                 |
| <input type="checkbox"/> Heart Attack                                    | <input type="checkbox"/> Asthma <b>INHALER Y/N</b> | <input type="checkbox"/> Sinus problems                            |
| <input type="checkbox"/> Rheumatic Fever                                 | <input type="checkbox"/> Mouth sores (herpes)      | <input type="checkbox"/> Heart murmur                              |
| <input type="checkbox"/> Fainting  | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Heart disease                             |
| <input type="checkbox"/> Diabetes <b>INSULIN Y/N</b>                     | <input type="checkbox"/> Nervous problems          | <input type="checkbox"/> Sexually Transmitted Disease              |
| <input type="checkbox"/> Respiratory problems                            | <input type="checkbox"/> Epilepsy / Convulsions    | <input type="checkbox"/> Stomach problems / Ulcers                 |
| <input type="checkbox"/> Mitral Valve Prolapse                           | <input type="checkbox"/> AIDS / HIV infection      | <input type="checkbox"/> Stroke                                    |
| <input type="checkbox"/> Artificial: joints/ implants/ valves/ pacemaker | <input type="checkbox"/> Rapid weight gain / loss  | <input type="checkbox"/> Kidney Disease                            |
| Describe _____   | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Chest Pains                               |
| <input type="checkbox"/> Hepatitis ( <b>TYPE</b> _____)                  | <input type="checkbox"/> Psychiatric care          | <input type="checkbox"/> Thyroid disease/malfunction               |
|  | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Cancer (growths/tumors) <b>CHEMO. Y/N</b> |
|  | <input type="checkbox"/> Alcohol / Substance Abuse | <input type="checkbox"/> Jaundice                                  |

**WOMEN ONLY : (please circle if applic.)**

**\*Are you pregnant?** Y N **\*Are you nursing?** Y N **\*Are you taking oral contraceptives** Y N

**CONSENT FOR TREATMENT**  
**& USE OF YOUR PERSONAL INFORMATION**

- I have reviewed all information on this questionnaire and it is accurate to the best of my knowledge.  
I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment.

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West 17 Avenue Dental Care is in compliance with all the guidelines of the revised 'Privacy Act'. We cannot discuss your personal information at the front desk, however we do need to keep this data updated.

If there is any change in your personal information, please inform a Team member **before** commencing your scheduled treatment for that day (including address or insurance status changes).

This information will only be used in a responsible and professional manner.

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- ***I agree to be responsible for payment of all services rendered on my behalf or my dependants.***  
***I understand that payment is due at the time of service.***  
***Any other arrangements must be made ahead of time.***
  - I understand if I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. A finance charge of 24% per annum of the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are made. If an account requires an outside party for collection, a collection fee will also be added to the account. (30% +tax of the total balance owing)

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***If you have dental insurance, we recommend that you contact your insurance company directly with any questions.*** In accordance with the 'Privacy Act' this information is considered "confidential medical information" and as such, it will **NOT** be released to us.

This office will help prepare the patients' insurance forms, however this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Our fees reflect the current cost of our supplies, equipment, education, and services, and

***it is likely that there will be a difference between our current fees  
and the fees used by your dental insurance plan.***

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- I understand as a condition of treatment by this office, **cancellations or changes require 48 hours notice** given directly to administration personnel, not the answering service.

***If appropriate notice is not received, a fee may be incurred, (\$30.00 per 1/2 hour missed)***

and I agree that this, as well as any previous outstanding balances, will be my responsibility.

- I understand that the fee estimate listed for my dental care will only be extended for a period of 30 days from the date of the patient examination.



I have read the above conditions of treatment and payment and agree to their content.

I consent to the collection, use and disclosure of my personal information as set out above

✕ \_\_\_\_\_

***Signature of patient, parent or guardian***

\_\_\_\_\_

***Date***