GEORGETOWN DENTAL CLINIC

New Patient Information Form

Personal Information

Name: (first and last)		
Preferred Name:		Mr. Ms. Mrs. Miss. Dr. (circle one)
Home Address:		**Contact Information**:
Number and Street:		Home Phone:
Unit:	City:	Work Phone:
Postal Code:		Cell Phone:
Date of Birth: (dd/mm/yyyy):		Email address:
Preferred method of communication (circle) Home phone work phone cell phone		Occupation:
Emergency Contact Name:		Emergency Contact Phone Number;
Relationship to Patient:		Family member responsible for this account:
Who can we thank for referring you?		

Insurance Information

Name of policy holder:		Relationship to patient:
Address:		
Date of Birth (dd/mm/yyyy):		
Insurance Company:		Employer:
Division:	Policy/Group:	Certificate ID:
Name of Secondary policy holder:(if applicable):		
Address:		
Date of Birth (dd/mm/yyyy):		Relationship to patient:
Insurance Company:		Employer:
Division:	Policy/Group:	Certificate ID:

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Medical Information

Physician: (name and phone)	Physician: (address)
Please list any medical conditions for which you are being treated or have been treated for:	
Approximate date of last medical check-up:	OHIP#

Please list any medications or herbal supplements you are currently taking:	
Medications:	Reason:

Do you have an allergy to any of the following (please check)?

o Penicillin	o Codeine	o Latex/rubber	o Local Anesthetic
o Metals	o Sulfonamide	o General Anesthetic	o Other

Please indicate if you have or have ever had any of the following conditions (please check)

o Blood Pressure o Heart Transplant o Other Heart Conditions o Stroke o Prosthetic Heart Valve o Compromised Immune System o Artificial Joint (date of surgery) o _____ o Thyroid Problems	o Pacemaker o Infective Endocarditis o Bleeding Problems or bruise Easily o Alcohol/Drug Dependence o Cocaine/Amphetamine use o Diabetes o Stomach Problems o Epilepsy o Kidney Disease o Tuberculosis	o Chest pain/Angina o Congenital Heart Disease o Jaundice/Hepatitis/Liver Disease o Osteoporosis o Asthma o Emphysema/COPD o Cancer (indicate type): o _____ o Chemotherapy/Radiation
o Do you have any other medical conditions of which the dentist or hygienist should be aware?		

Female Patients

o Currently Pregnant	o Currently Breast Feeding

GEORGETOWN DENTAL CLINIC

Dental Information

Previous Dentist:	Located in (town/city):
When was your last dental visit?	Treatment provided?
When did you last have dental x-rays?	Last cleaning?
If you have been seeing a dentist regularly, how often were your cleanings?	
How often do you brush your teeth?	How often do you floss your teeth?
Do you have any specific concerns about your oral health? (explain)	

Please circle the following (yes or no)

Do you require antibiotic pre-medication prior to a dental cleaning or treatment (due to heart condition prosthetic joint, etc.?	Yes No
Do you wear any form of dentures?	Yes No
Is there discomfort associated with any of your teeth?	Yes No
Do your gums bleed when you brush?	Yes No
Do you have any pain when you chew?	Yes No
Do you clench or grind your teeth?	Yes No
Do you snore or have Obstructive Sleep Apnea?	Yes No
Do you have any missing teeth that you would like to investigate replacing?	Yes No
Have you sustained any injury to your jaw (sports, accident, etc.)?	Yes No
Have you ever had dental implant surgery?	Yes No
Is a dental specialist currently treating you? (explain)	
Would you like to learn more about whitening or cosmetic dentistry options?	Yes No
Are you anxious or fearful about dental appointments?	
If so, rate your anxiety as (circle one): Mild Moderate Severe	
Please add anything else relevant about your dental history:	

General Consent Statement: 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, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatments to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all-inclusive.

I agree the Georgetown Dental Clinic has obtained informed consent from me with respect to the collection, use and disclosure of my personal information. I have been provided with a copy of the Privacy Code and agree that personal information may be collected, used and disclosed as set out in the Code and is in accordance with the Personal Health Information Protection Act, 2004.

I am aware that missing an appointment or failing to give 24 hours' notice for a cancellation may result in a cancellation fee.

Consent to Electronic Submission of Insurance Claims: I authorize release, to my benefits plan administer and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of service described to Georgetown Dental Clinic. This authorization shall continue until the undersigned revokes the same.

Patient/Parent or Guardian Signature: _____ Date: _____