

Adult



Pine Ridge Dental Centre

Welcome

We would like to welcome you to Pine Ridge Dental Centre. In an effort to provide the best service possible, we ask that you fill out this form. This information is kept confidential and may be important if we ever need to prescribe drugs or in the event of any emergency. Thank you for your cooperation.

Patient Information – Adult

Title (optional) Mr. Mrs. Miss. Ms. Dr.

Patient's Name (First) _____ Middle _____ Last _____

Age _____ Birth Date _____ Nickname (if preferred) _____ Male Female

Patient's Home Phone _____ Business Phone _____ Cell Phone _____

Patients Home Address _____ Unit _____

City _____ Province _____ Postal Code _____

Previous Dentist _____ Address _____ Phone _____

Have we treated another member of your family? Yes No

If Yes, Name (First) _____ Middle _____ Last _____

Spouse's name if applicable _____

How were you referred to our office? _____

Existing patient Banner Website Ad Mailer Other

Insurance Information

Primary Insurance

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____ Cert# _____

Insured's Name _____ Insured's Birth Date _____

Relationship _____

Insured's Employer _____ Employer's Address _____

Secondary Insurance

Insurance Company Name _____ Insurance Company Phone _____

Insurance Company Address _____ Group or Plan _____ Cert# _____

Insured's Name _____ Insured's Birth Date _____

Relationship _____

Insured's Employer _____ Employer's Address _____

Medical History

Are you in good health? Yes No

Are you currently under the care of a physician? Yes No

If yes, give details _____

Physician _____ Phone _____

Have you had a recent medical exam? Yes No

Ever been seriously ill or had major surgery? Yes No

If yes, give details _____

Any sensitivities or allergies to food or drugs? Yes No

If yes, give details _____

Are you taking any medication? Yes No

If yes, please list drug _____ dose/amount _____

Have you ever taken the drug Fen-phen? Yes No

Do you have any prosthetic joints? Yes No

Do you require antibiotics before dental treatment? Yes No

If yes, please explain _____

Any allergies to antibiotics / penicillins? Yes No _____

Any problems or allergies with local anesthetics? Yes No _____

For women: Are you pregnant? Yes No If yes, what stage? _____

- | | | | |
|--|--|---|--|
| • Do you bleed or bruise excessively? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you ever had sinus problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Have you ever fainted? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you ever had stomach problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Are you ever short of breath? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you had any form of diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Have you ever had chest pains? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you had any kidney problems? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Do you take any blood thinners? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you been anemic? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Have you gained or lost excessive weight? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you ever had chemo or radiation therapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Do you suffer from asthma? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you ever had liver disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Have you ever had a chronic cough? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Have you ever had hepatitis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Have you ever had heart problems or murmurs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Are you HIV positive? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Have you ever had lung disorders? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Do you have AIDS? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please explain any other medical issues _____

Dental History

When were you last at a dentist? _____ What was done? _____

Are you happy with the appearance of your teeth? Yes No

Are you happy with the alignment of your teeth? Yes No

Have you had a complete dental exam and full series of x-rays in the last 3 years? Yes No *(Insurance often limits these services to 3 years)*

Do you have a breath problem that concerns you? Yes No

Do your gums bleed when you brush your teeth? Yes No

Ever had a bad experience at the dentist? Yes No Explain _____

Have you had any of the following treatments?

- | | | |
|--|--|---|
| <input type="checkbox"/> Root Canal | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Full or partial dentures |
| <input type="checkbox"/> Crowns (caps) | <input type="checkbox"/> Periodontal (gum) treatment | <input type="checkbox"/> Bridgework |
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Cosmetic treatment |

Have you ever had extractions? Yes No

Did you have prolonged bleeding after? Yes No

Do you have a current dental problem? Yes No Explain _____

Have you sustained any injuries to your face, mouth or chin? Yes No

Have you ever had pain or tenderness in your jaw joints (TMJ) Yes No

Signature

I understand that the information that I have provided is correct to the best of my knowledge and that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination and treatment as advised by the doctor. Payment is due when services are rendered. Alternate payment arrangements must be made in advance of treatment. Payment methods include VISA, MasterCard, Direct Debit, and cash.

Signature _____ Date _____