

WATERLOO SMILES DENTISTRY

Patient Information			
Patient Name _____	Date of Birth _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
Street	Apt.#	<input type="checkbox"/> Separated	<input type="checkbox"/> Common Law
_____	_____	<input type="checkbox"/> Single	<input type="checkbox"/> Child
City	Province	<input type="checkbox"/> Other _____	
Phone (H): _____	(W): _____	Ext: _____	Best time to call: _____
E-Mail: _____	Fax: _____	Mobile/Cell: _____	

Employment/Insurance Information			
Employer: _____	Occupation: _____		
_____	_____	_____	_____
Street	City	Province	Postal Code
Insurance Company: _____	Policy # _____	Certificate # _____	
Secondary Insurance: _____	Policy # _____	Certificate # _____	
Patients relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			

Medical Information and Medical History		
Family Doctor: _____	Phone # _____	
Pharmacy Name/Location: _____	Phone # _____	
Emergency Contact: _____	Relationship _____	
Name	Phone #	

• Are you currently in Good Health?	Y N	If no, please explain: _____
• Are you currently (or in the past 5 years) being treated for any medical Condition(s)?	Y N	If yes, please explain: _____
• Has there been any change in your Medical health in past year?	Y N	If yes, please explain: _____
• Are you taking any Medications?	Y N	If yes, please explain: _____
• Do you have any allergies?	Y N	If yes, please explain: _____
• Have you ever had a peculiar or adverse reaction to any Medications?	Y N	If yes, please explain: _____
• Have you ever been hospitalized for any illness or operation?	Y N	If yes, please explain: _____
• Do you have any conditions which would affect your immune system? HIV, radiation, chemo...	Y N	If yes, please explain: _____
• Do you have a bleeding disorder?	Y N	If yes, please explain: _____
• Are there any diseases or medical problems that run in your family?	Y N	If yes, please explain: _____
• Do/did you have Asthma?	Y N	
• Do/did you have a heart murmur/mitral value prolapse or rheumatic fever?	Y N	
• Do you have a prosthetic or artificial joint?	Y N	
• Do you have heart/blood pressure problems?	Y N	
• Do you smoke?	Y N	If yes, how much: _____
• Have you ever been advised to take antibiotics prior to dental treatment?	Y N	
• Are you pregnant or trying to be?	Y N	
• Have you had hepatitis, jaundice or liver disease?	Y N	

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Medical Information and Medical History cont...

Have you had any of the Diseases Below? (Check all that apply)

- | | | | | |
|--|--|-----------------------------------|--|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Steroid Therapy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stomach Ulcer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diet Pill Therapy | <input type="checkbox"/> Drug/Alcohol Depend | <input type="checkbox"/> Anemia | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hormone Therapy | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Herbal Therapy | <input type="checkbox"/> Depression |

Dental Information and Dental History

- | | |
|--|--|
| <ul style="list-style-type: none"> • Reason for visit: _____ • Have you ever had any past bad experience in the dental office? Y N • Do you have partial or full dentures? Y N • Do you clench or grind while asleep or awake? Y N • Do you have any pain in your teeth or gums? Y N • Does your Jaw ever feel tired or sore? Y N • How often do you brush your teeth? () x day/week • Please rate your dental health.
1 2 3 4 5 6 7 8 9 10 • Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10 | <ul style="list-style-type: none"> • Date of Last Dental visit: _____ If yes, please explain: _____ If yes, how old is/are the denture(s): _____ • Do your gums feel tender, swollen or bleed? Y N • Are you interested in having Whiter Teeth? Y N • Are you happy with your Smile? Y N • How often do you Floss? () x day/week • Please rate your smile.
1 2 3 4 5 6 7 8 9 10 • Where would you like your smile to be?
1 2 3 4 5 6 7 8 9 10 |
|--|--|

Have you ever had? (check all that apply)

- | | | | | |
|--------------------------------------|-------------------------------------|----------------------------------|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Gum Surgery | <input type="checkbox"/> Crowns | <input type="checkbox"/> Veneers | <input type="checkbox"/> Bridge | <input type="checkbox"/> Extractions |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Root Canal | | | |

Referral Information

How were you referred to our practice?

- | | | | | |
|--|---|--|---------------------------------|-------------------------------|
| <input type="checkbox"/> Friend/Family | <input type="checkbox"/> Doctor/Dentist | <input type="checkbox"/> Dental Practice | <input type="checkbox"/> School | <input type="checkbox"/> Work |
| <input type="checkbox"/> Internet | <input type="checkbox"/> Other: _____ | | | |

Name of Person, Business, Office, Webpage: _____

If you used an internet search engine, please list keywords used: _____

Consent for Services

As a condition of our treatment by this office, financial arrangements must be made in advance. The practice depends upon payments from the patients for the cost incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial agreements must be paid for in cash or credit card at the time services are performed.

A service charge of 2% per month on the unpaid balance will be charged on all accounts exceeding thirty (30) days, unless previously written financial arrangement are agreed upon by the office.

I understand that any fee estimate provided by this office for my dental care can only be extended for a period of three (3) months from the date of the patient examination.

In consideration for the professional services rendered to me or at my request by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or her assignee, at the time said services are rendered.

I understand and acknowledge that photographs and images of me may be shown to other patients and doctors for treatment and educational purposes, and I agree to the same.

Further, I here by authorize Dr. Husain and her staff to speak to any insurance company, dental laboratory, or referred specialist on my behalf.

I here by agree to the terms above: _____ Date: _____

Patient/Guardian Signature

Dr.Husain Signature: _____ Date: _____

Dentist Notes: _____