WATERLOO SMILES

Patient Information

Patient Name_____ Date of Birth_____

_____
Street Apt.#

_____
City Province Postal Code

❑ Male ❑ Female
❑ Married ❑ Divorced
❑ Separated ❑ Common Law
❑ Single ❑ Child
❑ Other_____

Phone (H): _____ (W): _____ Ext: _____ Best time to call: _____
E-Mail: _____ Mobile/Cell: _____

Employment/Insurance Information

Employer: _____ Occupation: _____

Insurance Company: _____ Policy # _____ Certificate # _____
Secondary Insurance: _____ Policy # _____ Certificate # _____
Patients relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ 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 valve 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: _____
• Alcohol Consumption_____ /day_____/week		
• Due you use Recreational Drugs? Y N list:_____		
• 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)

❑ Chest Pain	❑ Heart Attack	❑ Stroke	❑ Shortness of Breath	❑ Pacemaker
❑ Lung Disease	❑ Tuberculosis	❑ Cancer	❑ Steroid Therapy	❑ Diabetes
❑ Stomach Ulcer	❑ Arthritis	❑ Seizures	❑ Kidney Disease	❑ Thyroid Disease
❑ Diet Pill Therapy	❑ Drug/Alcohol Depend	❑ Anemia	❑ Sinus problems	❑ Swollen Ankles
❑ Bulimia	❑ Hormone Therapy	❑ Anxiety	❑ Herbal Therapy	❑ Depression

Dental Information and Dental History

- 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
- 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

BP:_____ Weight:_____lbs/kg

Have you ever had? (check all that apply)

❑ Gum Surgery	❑ Crowns	❑ Veneers	❑ Bridge	❑ Extractions
❑ Implants	❑ Root Canal			

Referral Information

How were you referred to our practice?

❑ Friend/Family ❑ Doctor/Dentist ❑ Dental Practice ❑ School ❑ Work

❑ Internet ❑ 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 the Doctor and 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

Doctor Signature: _____ Date: _____

Dentist Notes: _____