ROSEDALE DENTAL CARE
NEW PATIENT FORM

Title: Mr. Mrs. Miss. Dr. Other___

Name:_____

(First) (Last)

Date of Birth (DD/MM/YYYY): _____

Home Address:_____

Suite ___City: _____Prov.___Postal Code_____

Cellular Phone _____

Home Phone _____

Business Phone _____

Email:_____

Occupation_____

How did you hear about our office?_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY

Name:_____

Relationship:_____Phone:_____

Name of Family Doctor:_____

Phone: _____

Address: _____

OHIP Number:_____

Do you have Dental insurance? Yes No

If yes then please provide following information:

Name of Insurance company: _____

Primary Ins. Policy# & Cert.#:_____

Sec Ins. Policy# & Cert.#:_____

MEDICAL HISTORY The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year?
   Yes/ No/ Maybe If so why_____
2. When was your last medical checkup?_____
3. Have there been any changes in your general health in the past year? If yes, please explain.
   Yes/No /Maybe _____
4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? **Yes/ No**
   If yes, please list _____
5. Do you have any allergies? **Yes/ No/ Maybe** If yes, please List

a) Medication_____b) Latex/ rubber products/ metals_____c) Other:_____

6. Have you ever had a peculiar or adverse reaction to any medications or injections? **Yes/ No/ Maybe**

   If yes, please explain_____
7. Have you ever been hospitalized for Illness and operations? **Yes/ No** if yes please explain_____
8. Do you smoke or chew tobacco products, cannabis? **Yes/ No** if yes which ones_____

   How many per day_____ Number of years_____

DO YOU HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING <u>PLEASE CIRCLE YES OR NO</u>

Anemia Y/N	Jaundice Y/N	AIDS Y/N	Tuberculosis Y/N
High Blood Pressure Y/N	Hepatitis Y/N	HIV Y/N	Cancer Y/N
Diabetes Y/N	Bulimia Y/N	Blood Disorders Y/N	Leukemia Y/N
Thyroid Disease Y/N	Kidney Disease Y/N	Arthritis/Rheumatism Y/N	Radiation Y/N
Asthma Y/N	Osteoporosis Medication	Artificial Joint Y/N	Chemotherapy Y/N
Bronchitis/ Emphysema Y/N	(e.g. Fosamax, Actonel) Y/N	Anorexia Nervosa Y/N	Organ Transplant Y/N
Lung disease Y/N	Glaucoma Y/N	Stroke Y/N	Sinus trouble Y/N
Angina Y/N	Steroid Treatment Y/N	Migraine/Headaches Y/N	Sleep Apnea Y/N
Arrhythmia Y/N	Drug/Alcohol dependency Y/N	Mental Health Dis Y/N	Gastrointestinal issues Y/N
Angioplasty/Stents Y/N	Heart Surgery Y/N	Multiple sclerosis Y/N	Venereal Disease Y/N
Heart Attack Y/N	Congenital Heart Defect Y/N	Epilepsy/seizures Y/N	
Pacemaker Y/N	Rheumatic Fever Y/N	Head/Neck Injuries Y/N	Any other condition not listed above:

<u>FOR WOMEN ONLY</u> 1) Are you pregnant? **Y/ N/ Maybe** if yes: Expected delivery date:_____

2) Are you breast feeding? Y/N/Maybe

3) Are you on any oral contraceptives? Y/N/Maybe

DENTAL HISTORY

1. Last dental visit? _____
2. What was done on the last visit_____
3. How frequently do you see your dentist? _____
4. What are your present dental concerns? If any please circle

   Bleeding Gums - Cracked Teeth - Cosmetic - Loose Teeth - Bad breath - Food getting caught - Toothache

   Loose Dentures- Missing Teeth - Other_____
5. How would you describe your dental health at present? Good Fair Poor
6. Are you satisfied with the appearance of your teeth? Y / N Are any of your teeth sensitive to heat, cold, sweets or pressure? Y/N
7. Do your gums bleed when brushing, flossing or eating? Y / N
8. Are you anxious during dental visits? Y / N

PATIENT CERTIFICATION AND CONSENT

I understand clearly that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I understand that information provided from or to my medical doctor or other health care provider may be necessary and I consent to the release of this information. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purpose of processing insurance claims and the determination of benefits. I authorize the dentist to treat me, and I assume full responsibility for the fees.

Signature of Patient/ Parent or guardian if under 16 _____ Date _____

Signature of Dentist_____ Date _____