ArtDent Family Dentistry

A parent/guardian will be responsible for decisions on my treatment					Yes □	No □
First Name	Last Name				Initial	
Street	Apt	City	Prov.	Postal Code		
Date of Birth (dd/mm/yy)	Home Tel.: ( ) -			Single □	Married □	Divorced □
Employer				Work Tel.: ( ) -		
Email Address			Emergency contact			
Family Doctor				Tel.: ( ) -		
How did you hear about us?						

Dental Insurance Information

If you have dental insurance please provide following information:	
Insurance company name:	Name of Insured:
Policy / plan #	ID / Certificate #
Insurance company name:	Name of Insured:
Policy / plan #	ID / Certificate #

Medical History

1. Are you presently under the care of a physician?				***Yes*** □	***No*** □
If so, please explain					
2. You ever been hospitalized?				***Yes*** □	***No*** □
If so, please explain					
3. Are you taking any drugs or medications at this time?				***Yes*** □	***No*** □
A) Drug----------Reason----------					
B) Drug----------Reason----------					
4. Have you ever had adverse effect to any of the following?					
Antibiotic □	Penicillin □	Sulfonamide □	Aspirin □	Barbiturates (sleeping pills) □	
Codeine □	Darvon □	Local Anesthetic □		None □	
5. Have you ever been warned against using any medication?				***Yes*** □	***No*** □
If yes, please specify which					
6. Have you ever taken prolonged medical or non-medical drugs?				***Yes*** □	***No*** □
If yes, please specify which					
7. Do you bruise easily or have prolonged bleeding?				***Yes*** □	***No*** □
8. Do you smoke? How many per day?				***Yes*** □	***No*** □
9. Have you ever fainted, had shortness of breath or chest pains?				***Yes*** □	***No*** □

LADIES:

Are you pregnant?	***Yes*** □	***No*** □
Using birth control?	***Yes*** □	***No*** □
Reached menopause?	***Yes*** □	***No*** □

CHILDREN:

Have you recently had any of the following? Please provide date					
Chicken Pox □	Measles □	Mumps □	Strep Throat □	Tonsillitis □	Other □

Do you have or have you ever had any of the following? Please check appropriate boxes.			
A.I.D.S □	Anemia □	Angina Pectoris □	Anorexia nervosa □
Artificial heart valve □	Arthritis/Rheumatism □	Artificial joints □	Asthma □
Blood disorders □	Bronchitis □	Bulimia □	Cancer □
Circulation problems □	congenital heart lesions □	Cortisone/Steroid □	Diabetes □
Drug/Alcohol dependence □	Emphysema □	Epilepsy □	Glandular disorders □
Glaucoma □	Head/neck injuries □	Heart disease/attack □	Heart murmur □

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Heart pacemaker/surgery □	Heart rhythm disorder □	Hepatitis A/B/C □	Herpes □
High/low blood pressure □	H.I.V positive □	Hodgkin's disease □	Hyper (Hypo) □
Hypertension □	Kidney disease □	Liver disease □	Liver disease □
Jaundice □	Mental/nervous disorder □	Mitral valve prolapsed □	Lung disease □
Malignant Hyperthermia □	Psychiatric disorder □	Radiation/chemotherapy □	Rheumatic/Scarlet fever □
Organ transplant/implant □	Sinus trouble □	Stomach/intestinal problems □	Stroke □
Sickle Cell Anemia □	Tuberculosis □	STD □	Leukemia □
Thyroid disease □	Ulcers □		
None □			

Dental History

What is the reason for today's visit?	Emergency □	Examination □	Other □	
How frequently do you see a dentist?	3-6 months □	annually □	Other □	
When was your last dental visit		Last X-Ray		
How often do you brush per day	Floss.	Use anti-bacterial rinse		
Are your teeth sensitive to	Cold □	Sweets □	Heat □	Other □
Do your gums bleed when:	Brushing □	Flossing □	Never □	

Do your gums feel swollen or tender?	***Yes*** □	***No*** □
Do you have bad breath or bad taste in your mouth?	***Yes*** □	***No*** □
Do your jaws crack, pop, or grate when you open widely?	***Yes*** □	***No*** □
Do you have food catch between your teeth?	***Yes*** □	***No*** □
Have you ever had local anesthetic (freezing)?	***Yes*** □	***No*** □

Have you ever had any problems with previous dental treatments?			
Have you ever had any of the following:	Bridgework □	Crowns or caps □	Root Canal □
Full or partial dentures □	Orthodontic (braces) □	Periodontal (Gums?) □	

Rate your smile from 1 to 10 (1=very unsatisfied, 10=very satisfied)

1□	2□	3□	4□	5□	6□	7□	8□	9□	10□

Would like to have whiter teeth	***Yes*** □	***No*** □
My teeth could be straighter or more proportional	***Yes*** □	***No*** □
I have one or more missing teeth	***Yes*** □	***No*** □
I have unattractive spaces between my teeth	***Yes*** □	***No*** □
Do you grind or clench your teeth?	***Yes*** □	***No*** □
Have you been told that you snore loudly?	***Yes*** □	***No*** □

Do you have trouble sleeping through the night? (E.g. falling asleep, staying asleep p, and/or tossing and turning)	
Yes □	***No*** □

Have you been diagnosed with a snoring or sleep apnea condition?	***Yes*** □	***No*** □
Do you have a CPAP machine?	***Yes*** □	***No*** □

General Release / patient consent

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment, and I authorize this dental office to perform general dental treatments. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibilities for fees associated with my dental treatment or dental diagnostic procedures. I hereby certify that I have been notified of the privacy policies of this office, who to contact regarding privacy concerns and ho to request further information.

I---------- Signature: Self ----------

Parent / guardian ---------- -Date ----------

Financial Information

Person responsible for financial matters: ☐Self ☐Spouse ☐Parent/Guardian ☐Other

Method of payment: ☐Cash ☐Debit ☐Credit Card ☐Other----------

I hereby acknowledge that I have fully read and understood the Dental Plan Co-payment and Patient Fact Sheet by Ontario Dental Association that is offered to me by ArtDent Family Dentistry and also acknowledge that I am financially responsible for all treatments with or without insurance coverage. I recognize that I am responsible at any time for the copayments or deductibles of the treatments that are deducted or not paid by my insurance companies
I acknowledge that I am fully responsible for the cost of treatments in the event that I cancel continuation of my treatments.

RELEASE OF RECORDS REQUESTED BY YOUR INSURANCE

I……..hereby give consent to release my x-ray/records to ……

If you have any further question please feel free to contact our office at 905.237.7842