dentistry in ajax

300 Rossland Rd. E., Unit 100
Ajax, ON L1Z 0M1

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 About You

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR | MRS | MS | DR

I prefer to be called: _____ ☐Male ☐Female

Birthdate: _____ Age: _____

Home Address: _____
APT/CONDO#

_____
CITY PROVINCE POSTAL CODE

Home#: _____ Cell#: _____

Work#: _____ Ext: _____

Employer: _____

Occupation: _____

Where & when are the best times to reach you?

_____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(PLEASE CIRCLE)

Last Visit Date: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Work#: _____ Home#: _____

Cell#: _____

2 Dental Insurance

Primary Dental Insurance

Insurance Company: _____

Group# (Plan, Local or Policy#): _____

ID or Certificate#: _____

Insured's Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Company: _____

Group# (Plan, Local or Policy#): _____

ID or Certificate#: _____

Insured's Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's Employer: _____

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3 Medical History

Do you have a personal physician? ☐Yes ☐No

Physician's Name: _____

Work#: _____ Date of last visit: _____

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

Please Explain: _____

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you taking an prescription / over-the-counter or supplement drugs? ☐Yes ☐ No

Please list each one: _____

_____

_____

Do you smoke or use tobacco in any other form? ☐Yes☐No

For Women: Are you using a prescribed method of birth control? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No Week#: _____

Are you nursing? ☐Yes ☐No

Have you ever had any of the following disease or medical problems? (Please check option that applies)

- ☐ Anemia / Radiation Treatment
- ☐ Artificial Bones / Joints / Valves
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer / Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug / Alcohol Abuse
- ☐ Emphysema / Glaucoma
- ☐ Epilepsy / Seizures / Fainting Spells
- ☐ Fever Blisters / Herpes
- ☐ Heart Attack / Stroke
- ☐ Heart Murmur
- ☐ Heart Surgery / Pacemaker
- ☐ Malignant Hyperthermia
- ☐ Hemophilia / Abnormal Bleeding
- ☐ Hepatitis
- ☐ High / Low Blood Pressure
- ☐ HIV & AIDS
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problems
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Problems
- ☐ Rheumatic / Scarlet Fever
- ☐ Severe / Frequent Headaches
- ☐ Shingles
- ☐ Sickle Cell Disease / Traits
- ☐ Sinus Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers / Colitis
- ☐ Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry / Metals
- ☐ Latex
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Other

Please list any other drugs / materials that you are allergic to:

_____

_____

4 Dental History

Why have you come to the dentist today?

Do you require antibiotics before dental treatment?☐Yes ☐No

Are you currently in pain? ☐Yes ☐No

Have you every had a serious / difficult problem associated with any previous dental work? ☐Yes ☐No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐Yes ☐No

Your current health is: ☐Good ☐Fair ☐Poor

Do you like your smile? ☐Yes ☐No

Do your gums ever bleed? ☐Yes ☐No

Have you ever had periodontal disease? ☐Yes ☐No

When was the last time you have seen a dentist? _____

Do you have a bad taste or smell in your mouth? _____

5 Authorization

I understand the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes to my medical status. **I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.**

_____

Signature Date

Payment is due at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

Our office is PHIPA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the CDA.

Office Use Only

I verbally reviewed the medical / dental information above with the patient named herein.

Initials: _____ Date: _____

Doctor's Comments: