DENTISTRY at CONSILIUM

Information and Health History

Dr./Mr./Mrs./Ms./Miss

Name: _____ D.O.B.: _____

Address: _____ Apt#:_____ City:_____

Postal Code: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Bus. Phone: _____

Name of Physician and Office #: _____

Referred By: _____

Name of Previous Dentist and Office #: _____

Party Responsible for Payment of Account (Self, spouse, parent): _____

Do you or the responsible party have insurance? Yes No

Insurance Information:
Dental Insurance Company: _____ Group/Policy#: _____ ID#: _____

Employer: _____

D.O.B. and contact # of plan holder (if not self): _____

1. Do you presently have any dental pain of problems? (Explain) _____
_____
2. How often do you clean your teeth and what do you use? _____
3. Do your gums bleed? Yes No
4. Do you have difficulty chewing your food? Yes No
5. Do you clench or grind your teeth? Yes No
6. Have you ever experienced prolonged bleeding or slow healing after a tooth extraction? Yes No
7. Have you ever had orthodontic treatment (braces)? Yes No
8. Have you ever been treated for periodontal disease (gum disease)? Yes No
9. Are you prone to infection? Yes No
10. Date of your last dental examination and x-rays: _____
11. Date of last physical examination: _____
12. Are you taking any drugs or medication daily (including aspirin)? _____
_____
13. Have you had surgery or serious illness within the last five years? _____

Have you had any of the following conditions?								
Rheumatic Fever	Y	N	Blood Disease	Y	N	Kidney Disorder	Y	N
Heart Disease	Y	N	Anaemia	Y	N	Respiratory Disorder (or TB)	Y	N
Stroke	Y	N	Diabetes	Y	N	Asthma	Y	N
Heart Murmur	Y	N	Liver Disorder (Hepatitis)	Y	N	Arthritis	Y	N
HIV/AIDS	Y	N	Glaucoma	Y	N	Artificial Joints or Hip	Y	N
High/low blood pressure	Y	N	Other	Y	N			

Over…

Are you allergic to any of the following?								
Latex	Y	N	Barbiturates, Sedatives	Y	N	Sleeping Pills	Y	N
Penicillin	Y	N	Codeine	Y	N	Aspirin	Y	N
Local Anaesthetics (Novocaine)	Y	N	Antibiotics (Sulfa etc)	Y	N	Other Drugs (Specify) _____ _____		

WOMEN:
Are you pregnant? Yes No
Are you taking oral contraceptives (birth control) or other hormones? Yes No

POLICIES OF THE OFFICE

Dental Office Cancellation and Missed Appointment Policy

In our office we respect everyone's time. For that reason, we have developed an office policy to inform you, our valued patient, that appointments are reserved especially to meet you and your family's needs. The length of your appointment is based on your individual treatment needs. Please respect this time. Should you have to change or cancel an appointment with less than two business days notice, our minimum cancellation fee is $50.00. Thank you for your understanding and we look forward to providing exceptional care for you and your family.

Payments

You are solely responsible for payments of all fees incurred during treatment. If you have dental insurance, please remember that your insurance plan is a contract between you and the insurance company. We do not render our services on the basis that insurance companies will cover all our charges. If we accept payment directly from your insurance company, you are responsible for all fees not covered by your insurance including deductibles, part payments, co-insurance deductibles and ABC clauses. Each treatment is structured to fit the patient's individual needs, not the insurers benefit package.

NSF Cheques

There will be a service charge levied for all cheques returned from the bank.

_____ _____

Signature **Date**

Information collected will only be used for office use and will not be shared without your written consent as per PIPEDA