

Village Dental

New Patient Form

4931 Dundas Street West
Etobicoke, Ontario M9A 1A4
Tel: 416-233-9638 Fax: 416-233-0617

Date ____ / ____ / ____
DD MM YYYY

Patient Information

Last Name _____ First Name _____
Address _____ Apt. _____
City _____ Province _____ Postal Code _____
E-mail Address _____
Home Ph. () _____ Bus. Ph. () _____ Cell Ph. () _____
Date of Birth ____ / ____ / ____ Male Female Marital Status _____
DD MM YYYY
Occupation _____ Employer _____
Emergency Contact _____ Tel. No. () _____ Relationship _____
Whom may we thank for referring you to our office? _____

Dental Insurance Information

Person responsible for financial matters: Self Spouse Parent/Guardian
If different from above, please complete the following:
Last Name _____ First Name _____
Address _____ Apt. _____
City _____ Province _____ Postal Code _____
E-mail Address _____
Home Ph. () _____ Bus. Ph. () _____ Cell Ph. () _____

Primary Insurance

Insurance Company _____
Policy Holder _____
Policy No. _____
Certificate/Employer's ID No. _____
Check-up Interval _____
Maximum Coverage _____ %
Basic _____ %
Major/Restorative _____ %
Ortho (Braces) _____ %

Secondary Insurance

Insurance Company _____
Policy Holder _____
Policy No. _____
Certificate/Employer's ID No. _____
Check-up Interval _____
Maximum Coverage _____ %
Basic _____ %
Major/Restorative _____ %
Ortho (Braces) _____ %

Medical History Information

Family Physician _____ Tel. No. () _____
1. Date of last visit to your physician ____ / ____ / ____ For what purpose? _____
DD MM YYYY
2. Generally, are you in good health? Yes No
3. Have you ever had a serious illness or been hospitalized? Yes No
If so, please explain _____
4. Are you taking any prescription drugs, over the counter medications or herbal remedies?
Drug _____ Dosage _____ Reason _____
Drug _____ Dosage _____ Reason _____
Drug _____ Dosage _____ Reason _____
Drug _____ Dosage _____ Reason _____
5. Have you ever had an allergic reaction or adverse effect to any of the following:
 Aspirin Codeine Penicillin Sulfonamide Sleeping pills Local anaesthetic

6. Do you suffer from any allergies to the following:
 Latex Metals Food fever Other _____
7. Do you bruise easily or have prolonged bleeding? Yes No
8. Do you smoke? If so, how much? Yes No
9. Have you ever fainted, had shortness of breath or chest pains? Yes No
10. WOMEN: Are you pregnant? Yes No
 Are you taking birth control pills? Yes No
11. Do you have or have you ever had any of the following?
- | | | |
|---|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Angina | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mental/Psychiatric Disorder |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Artificial Joints (hips/knees) | <input type="checkbox"/> Organ Transplant/Implant |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Radiation / Chemotherapy | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Drug/Alcohol Dependence | <input type="checkbox"/> Stomach/Intestinal Problem |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Head/Neck Injuries | <input type="checkbox"/> Tuberculosis Liver Disease |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Hodgkin's Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hyper/Hypo Glycemia |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other _____ | |

Dental History Information

Previous Dentist _____ Tel. No. () _____

1. Date of last visit to your dentist ____/____/____ For what purpose? _____
 DD MM YYYY
2. What is the reason for today's visit? Emergency Examination Other _____
3. How frequently do you see a dentist? 3-6 months Annually Other _____
4. When was your last dental visit? _____ Last dental x-rays _____
5. How often do you brush per day? _____ Floss _____ Use antibacterial mouth rinse _____
6. Are your teeth sensitive to: Hot Cold Sweets Other _____
7. Do your gums bleed when: Brushing Flossing Never
8. Have you ever had any of the following treatments?
 Bridgework Crowns or Caps Full or Partial Dentures
 Orthodontic (Braces) Periodontal/Gum Surgery Root Canal
9. Do your gums feel swollen or tender? Yes No
10. Do you have bad breath or a bad taste in your mouth? Yes No
11. Do your jaws crack, pop or snap when you open widely? Yes No
12. Do you get food caught between your teeth? Yes No
13. Do you grind or clench your teeth? Yes No
14. Have you ever had any complications with local anesthetic (freezing) Yes No
15. Have you ever had any problems with a dental treatment? Yes No
16. Are you satisfied with the appearance of your teeth? Yes No
17. What would you like to change, if anything? Yes No

GENERAL RELEASE: I, the undersigned, understand that the information contained in the dental and medical history portion of this chart is important to my treatment. I certify that all the information is correct and that I have not knowingly omitted any information. I consent to the release of medical information from my medical doctor or other health provider as required by Village Dental. I authorize Village Dental to perform diagnostic procedures as may be required to determine necessary treatment. I assume all responsibility for fees associated with my dental treatment and/or dental diagnostic procedures.

Patient's Signature _____ Date ____/____/____
 DD MM YYYY