DS Designer Smiles
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PATIENT INFORMATION Please Print Clearly

To help ensure your well being while undergoing treatment in our office please answer the following questions. Naturally any information will be considered confidential and for our records only. You may ask to see our privacy agreements at any time.

Name (Last/ First)____ Dr. Mrs. Mr. Miss Ms (Please circle one)
Address____
City/Province ____ Postal Code__________________
Home Phone________________ Work Phone__________________ Cell ____________________
Patient Email ____
Do you consent to having us contact you by e-mail? (Please check one) Yes_____ No_______
Date of Birth: Day____ Month _____Year ____ Age____ Health Care Number __________________
Employer ____
Referring Dentist or Doctor____
Family Dentist______________________ Family Physician______________________________
Purpose of this visit ____

PARENT / GUARDIAN / SPOUSE INFORMATION

(Person Financially Responsible)

Name __________________________________ Relationship to Patient ____________________
Address (if different from above)____
City____________________ Postal Code_______________ Home Phone__________________
Employer__________________ Work Phone___________________ Cell ____________________

DENTAL INSURANCE INFORMATION

Name of Insurance Company____
Policy/Group # ______________________Certificate / I.D. # ___________________________
Subscriber's Name: ____
Subscriber's Employer:____
DOB: (DD/MM/YY)_________________________Relationship to Patient ____________________
If you have **dual insurance**, please complete information for 2nd subscriber:
Name of Insurance Company ____
Policy / Group # _____________________ Certificate / I.D. # ___________________________
Subscriber's Name: ____
Subscriber's Employer:____
DOB: (DD/MM/YY)_________________________Relationship to Patient:____________________
Is this a Workman's Compensation claim? If so Claim #______________________________
If you are covered by Social Assistance, please present your card. I.D. #____________________

DENTAL HISTORY

Are you experiencing any pain at this time? .... Yes ❑ No ❑
Do you clench or grind your teeth? .... Yes ❑ No ❑
Do you currently wear a nightguard?.. Yes ❑ No ❑
Have you had any problems with local anesthetic (freezing)? .... Yes ❑ No ❑

MEDICATIONS

Do you have any allergies or unusual reactions to any medications or foods? .... Yes ❑ No ❑
....
....
Please list all medications/pills/**herbal medicines** you are taking or have been taking **including their frequency & dosage.**
....
....
Are you allergic to quetiapine fumarate?... Yes ❑ No ❑
Are you currently or have you in the past taken bisphosphonates? .... Yes ❑ No ❑
Please list any disabilities
....

MEDICAL HISTORY

Have you had any previous serious illnesses? (please list) .... Yes ❑ No ❑
....
....
Have you ever had a general anesthetic or previous surgery (please list below)? .... Yes ❑ No ❑
....
....
Have you or any member of your family ever had a bad reaction to general anesthetic? ..... Yes ❑ No ❑
Do you have high blood pressure? .... Yes ❑ No ❑
Have you ever had rheumatic fever or scarlet fever? .... Yes ❑ No ❑
Do you have a history of glaucoma? .... Yes ❑ No ❑
Do you have a heart murmur? .... Yes ❑ No ❑
Do you have any heart problems?... Yes ❑ No ❑
Do you have any liver disease? .... Yes ❑ No ❑
Do you have any kidney disease? .... Yes ❑ No ❑
Do you have diabetes? .... Yes ❑ No ❑
Do you have any breathing or lung problems (bronchitis, etc.)? .... Yes ❑ No ❑
Do you have any asthma? .... Yes ❑ No ❑
If yes, list medication taken ....
Last attack .... Frequency of attacks ....
Have you ever been hospitalized .... Yes ❑ No ❑
If yes, last visit .... Were you admitted? Yes ❑ No ❑
Do you suffer from stomach ulcers or other gastrointestinal disease? .... Yes ❑ No ❑
Have you ever been tested for A.I.D.S./HIV? When............. Results .... Yes ❑ No ❑
Have you ever been tested for Hepatitis A, B, or C? When.............. Results .... Yes ❑ No ❑
Have you had a bleeding problem or blood disorder? .... Yes ❑ No ❑

Have you ever had a seizure? .... Yes ❑ No ❑
(Women only) Do you think you might be pregnant/Are you nursing? .... Yes ❑ No ❑
Do you smoke? If so, how much? .... Yes ❑ No ❑
Do you use any street drugs? .... Yes ❑ No ❑
Are you suffering from any psychological or mental disorders and/or handicaps? .... Yes ❑ No ❑
Have you had a cough or shortness of breath in the past 24 hours?.............................. Yes ❑ No ❑
Have you had a fever or chills in the past 24 hours?... Yes ❑ No ❑
Have you had a new or recent onset of diarrhea? .... Yes ❑ No ❑
Do you have a new undiagnosed rash, lesion or break in the skin?................................ Yes ❑ No ❑
Have you recently been exposed to any communicable infectious diseases? .... Yes ❑ No ❑
(e.g. , measles, chicken pox, or tuberculosis)
Have you recently travelled to areas where endemic diseases are present? .... Yes ❑ No ❑
Country visited____
Have you had a joint prosthesis procedure in the past two years? .... Yes ❑ No ❑
Please fill in: Current Height ______________ Weight _____________

OFFICE POLICY

In order to prevent misunderstanding about dental or surgical insurance we wish our patients to know that all professional services provided are **CHARGED DIRECTLY TO THE PATIENT** and that **PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS.** We will prepare necessary reports to help collect your benefits from insurance companies. However, each fee is individual with the patient and not based on the assumption that the insurance companies will pay all of our charges.

APPOINTMENTS

Please help us to maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment this time is reserved for you; therefore at least **24 HOURS NOTICE** must be given if cancellation is absolutely necessary, otherwise a serious delay in treatment may develop and a **fee will be charged**.

CONSENT FOR TREATMENT

I, the undersigned, being the patient, parent or guardian of the above minor patient, confirm that to the best of my knowledge, the above information is correct. I consent to undergo the consultation appointment and understand that further treatment will not be provided until it has been presented to me and mutually agreed upon by myself and the doctor.

I also assume full responsibility for the payment of all such services, and agree to pay in full, at or before completion of treatment unless other arrangements are agreed upon, in advance.

Date: ______________Signature: ______________________________________Reviewed by: _____________