DENTAL SQUARE

8920 Highway 50, Unit E9, Brampton, ON Phone: 905-915-8988

PATIENT INFORMATION

Welcome to our office !to assist us in serving you, please complete the following form

Patient Name _____ Preferred name_____ Sex_____ Birth date_____
Home phone _____ Cell phone_____ Email_____
Address_____ City_____ Prov._____ Postal Code_____
Employer _____ Occupation_____ work phone_____
Spouse's name_____ Spouse's employer _____
Whom may we thank for referring to our office_____
Emergency contact name_____ Relation _____ Phone_____

Dental History

Reason for today's visit_____ Former Dentist name_____
Date of last dental visit_____ Date of last cleaning_____ Date of last Dental Xray_____

Do you have or have or have you had any of the following?(Please check any that apply)

□ Issue with previous treatments	□ Chew on one side of mouth	□ Grinding of teeth
□ Bad breath	□ Smoking	□ Gums swollen or tender
□ Bleeding Gums	□ Clicking or popping of jaw	□ Denture
□ Blisters on lips or mouths	□ Jaw pain /tenderness	□ Periodontal treatment
□ Food collection between teeth	□Loose teeth/Broken fillings	□ Mouth Breathing
□Orthodontic Treatment	□Pain around ear	□ Sensitivity to cold/ Sweet

Do you have any dental issues/concerns not listed above?_____

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Medical Health History

Do you have or have you had any of the following? Please check any that apply

□ Cancer or tumour
□ Heart disease
□ Artificial joint or valve
□ High or low blood pressure
□ Pacemaker
□ Tuberculosis or other lung problems
□ Kidney disease
□ Hepatitis or other liver disease
□ Alcoholism
□ Blood transfusion
□ Diabetes
□ Neurologic condition
□ Epilepsy ,seizures or fainting spells
□ Emotional conditions
□ Arthritis
□ Herpes or cold sores
□ AIDS or HIV positive
□ Migraine headaches or frequent headaches
□ Anaemia or blood disorders
□ Abnormal bleeding after extractions,surgery or trauma
□ Hayfever or sinus trouble
□ Allergies or hives
□ Asthma

Are you allergic to or have you reacted a adversely to:

□ Latex Materials
□ Penicillin or other antibiotics
□ Local anaesthetics (Novocain)
□ Codeine or other narcotics
□ Barbiturates, sedatives/sleeping pills
□ Aspirin
□ Other

Are you taking any of the following?

□ Aspirin □Anticoagulants □ Antibiotics or sulpha drugs □ Nitroglycerin
□ Cortisones or other steroids □ Antidepressents or tranquilizers
□ Osteoporosis (bone density medicine)
□ Insulin or any other diabetes drug
□ Other_____

Women □ May be pregnant
□ Taking hormones or contraceptives

Name of your physician:_____ Phone number:_____
Physician's address :_____
_____
_____

Do you have any disease or condition not listed above?_____

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Insurance information

Primary Dental Insurance:
Company and Telephone number: _____
Employer: _____
Group plan: _____
Group number: _____

Secondary Dental Insurance (Spousal, if applicable):
Company and Telephone number: _____
Employer: _____
Group plan: _____
Group number: _____

Note: You can scan and attach the copy of insurance card and send it to our office email: info@dental2.ca. Please bring your policy booklet from your insurance provider if you have. Also, if you have an online account, you may also download a copy of your policy in pdf format and email it to us.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist and I am financially responsible for any balance.

Signature of Patient(or Parent)_____ Date_____

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Express Consent for Email, Text, Social Media Communication

To comply with the Canadian Anti-Spam Legislation (CASL) that is in effect as of July 1, 2014, our dental office would like to have your express consent to continue communicating with you and providing you with important information from us. We are committed to never sending spam emails and our privacy policy will always protect your electronic information.

If you decide to opt in and continue receiving emails, please know that you may opt out at any time and withdraw your consent.

Please click on one of the links below and in the subject line tell us your preference by simply typing Opt In or Opt Out.

□ Yes, I consent to receiving valuable information from your Dental Office

□ No, thank you. I wish to opt out of future emails from your Dental Office

Note: If you have agreed to consent for electronic communication, please make sure you provide us with your email and cellular number

Signature of Patient(or Parent)_____ Date_____