PERSONAL INFORMATION

Name: Mr. / Mrs. / Miss / Ms / Dr ______________________________
Surname Given Name

Address: ______________________________
Number Street Apt

____
City Province Postal Code

Telephone: Home: ______________ Work: ______________ Cell: ______________

Email: ______________________________ **Birthday:** _____/_______/________
Day Month Year

Occupation: ______________________ Place of Business: ______________________

Marital Status: ☐Single ☐Married ☐Widow(er) ☐Other

How would you prefer we contact you? ☐Home phone ☐Cell phone ☐Text Message ☐Work telephone ☐Email

Personal Health Number: _____ _____ _____

In case of emergency please notify:

Name: ______________________________

Relationship: ______________________ Phone: ______________________

If patient is a minor or dependant, name of person legally responsible:

____
Name Phone Address

How did you hear about our office? ______________________________

DENTAL INSURANCE (Private or government agency)

PRIMARY INSURANCE

Name of Insured: ______________________ Date of Birth: _____/_____/______

Insurance Co ______________________ Employer: ______________________

Group #_______________ Division # _____ ID/Certificate #______________________

SECONDARY INSURANCE

Name of Insured: ______________________ Date of Birth: _____/_____/______

Insurance Co ______________________ Employer: ______________________

Group #_______________ Division # _____ ID/Certificate #______________________

MEDICAL HISTORY

1. Who is your family physician: ______________________________
   Name Phone
2. Have you been under the care of a physician in the past 12 months? Yes No
3. Please list all medications you are taking:______________________________

   ____

4. Please list any food or drug allergies: ______________________________
5. Do you have or have you ever had any of the following medical conditions?

   ☐ Artificial Joints ☐ Asthma ☐ Cancer
   ☐ Diabetes ☐ Epilepsy ☐ Heart Disease
   ☐ High Blood Pressure ☐ Hepatitis ☐ HIV / STD
   ☐ Osteoporosis ☐ Prosthetic Heart Valve

6. Do you bruise easily? Yes No Do you bleed abnormally? Yes No
7. Do you have any disease, condition or problem not listed that you feel we should know about?

   ____

8. WOMEN ONLY: Are you pregnant or nursing a baby? Yes No

DENTAL HISTORY

1. How frequently do you see a dentist: ☐ 6 months ☐ 9 months ☐ 1 year ☐ other
2. When was your last dental visit? ______________________________
3. Do you have trouble with local anaesthetic (freezing)? Yes No
4. Do you have problems chewing, clenching your teeth or with your jaw joint? Yes No
5. Are any of your teeth sensitive or loose? Yes No
6. Are you satisfied with the appearance of your teeth? Yes No

PATIENT CERTIFICATION AND CONSENT

I certify that all of the medical and dental information I have provided is true to my knowledge and I have not omitted any pertinent information. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable including the use of local anaesthetic as indicated and I will assume responsibility for the fees associated with these procedures. I acknowledge reviewing the Downtown Dental Associates Privacy Policy and I understand my rights of privacy with respect to my personal information. I further consent to the collection, use and disclosure of my personal information for the following purposes:

1. To provide me with dental services;
2. To maintain communications and provide me with information and follow up respecting my dental care;
3. To obtain payment of account
4. To submit insurance claims to my dental benefits plan administrator and CDA;
5. For uses, purposes and disclosure described in the Privacy Policy.

(OPTIONAL) Restricted Access: My personal information shall not be provided to the following individuals or organizations: ______________________________

(OPTIONAL) Restricted Information: Personal information disclosed from personal information collected shall not include: ______________________________