

Personal Information

First Name: _____ Last Name: _____ Preferred Name: _____

Date of Birth: _____ (DD) _____ (MM) _____ (YYYY)

Address: _____ City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Mobile Phone: _____ Email Address: _____

Emergency Contact Name: _____ Phone Number: _____ Relationship: _____

Primary Insurance Carrier: _____ Policy#: _____ ID# _____

Secondary Insurance Carrier: _____ Policy# _____ ID# _____

Secondary Holder Name: _____ Secondary Holder DOB: _____

Dental Health History

Date of last dental exam: _____ Date of last hygiene: _____ Date of last x-rays: _____

Do you have an immediate dental concern? _____

Do you see a dentist regularly? Yes ☐ No ☐ Sometimes ☐

How often do you brush your teeth? Twice a day ☐ Once a day ☐ Sometimes ☐ Never ☐

How often do you floss? Twice a day ☐ Once a day ☐ Sometimes ☐ Never ☐

Do you experience jaw discomfort? (i.e.:pain, tenderness, clicking) Yes ☐ No ☐

Have you ever had any trauma to the head, neck or face? Yes ☐ No ☐

If so, please explain: _____

Please check all that apply:

☐ Clenching or grinding

☐ Sensitive Teeth

☐ Gag reflex

☐ Wear a night guard or retainer

☐ Bad Breath

☐ Dental Anxiety

☐ Had orthodontic Treatment

☐ Food catches between teeth

☐ Snore/Mouth Breathing

Medical Health History

Medical Doctor: _____ Phone Number: _____ Date of Last Visit: _____

Have you ever been advised to take antibiotics before a dental appointment? Yes ☐ No ☐

Are you being treated for any medical conditions currently, or within the last two years? Yes ☐ No ☐

If so, please explain: _____

Have you had surgery or been hospitalized with any illness within the last two years? Yes ☐ No ☐

If so, please explain: _____

Have you ever had an adverse reaction to medication or injections? Yes ☐ No ☐

Do you have any allergies? _____

List all medications you are currently taking: _____

Do you smoke tobacco/vape, use cannabis/recreational drugs/alcohol? Please circle all that apply

How often? Daily ☐ Weekly ☐ Occasionally ☐ Never ☐

Are you taking birth control? Yes ☐ No ☐

Are you pregnant or breastfeeding? Yes ☐ No ☐

Please check all that apply:

Cardiovascular/Respiratory

- ☐ Angina
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Emphysema
- ☐ Endocarditis
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Valve Replacement

Haematological (Blood)

- ☐ Abnormal Bleeding

- ☐ Abnormal Bruising

- ☐ Blood Disorder
- ☐ Blood Transfusion

Immune System/Infectious Diseases

- ☐ Cold Sores
- ☐ HIV/AIDs

Endocrine

- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease

Gastrointestinal/Urinary

- ☐ Acid Reflux/GERD
- ☐ Crohn's Disease
- ☐ Hepatitis

- ☐ Stomach Ulcers

General

- ☐ Alzheimer's/Dementia
- ☐ Arthritis
- ☐ Cancer
- ☐ Epilepsy/Seizure
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Head/Neck Injury
- ☐ Hearing Impairment
- ☐ Joint Replacement
- ☐ Mental Health Illness
- ☐ Migraines/Headaches
- ☐ Osteoporosis
- ☐ Radiation Therapy
- ☐ Stroke

Other: _____

Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilize all personal information in a responsible and professional manner. This document summarizes the personal information we collect, use and disclose. In addition; we collect, use and disclose personal information when permitted or required by law.

Contact information is collected and used for the following purposes:

- To open and update patient files
- To invoice patients for dental services, to process credit card payment or to collect balances owing
- To process dental claims for reimbursement from third-party health benefit providers on behalf of patients'
- To send reminders to patient concerning the need for further dental treatment or reminders via text or email
- To send patient information about our dental practice

Patients' Medical Information May be disclosed to:

- Third-party health benefit providers for reimbursement of claims or estimates
- To other dentists or specialists, if the patient, with their consent, has been referred by our dentists for treatment
- To other dentists or specialists, where a second opinion may be required
- To other healthcare professionals such as physicians, if the patient, with their consent, has been referred to us, or by us to another healthcare professional

I, the undersigned, certify that to the best of my knowledge the information I have provided today is accurate. I have not knowingly omitted any information. I have had the opportunity to ask questions and answers where provided regarding my medical and dental health history. Should there be any change in either my health or personal information I will advise West 17 Avenue Dental Care. I understand that all information is collected in strict confidence and is solely used to improve communications between the dental office and myself. I authorize the dental staff to perform dental services that may be necessary and authorize the release of written records to any referring or treating dentist, physician, medical facility or health benefit provider, for legal documentation.

I have read the above personal information consent form and agree to terms:

Patient Name: _____ Signature: _____ Parent/Guardian: _____

Date: _____(DD) _____(MM) _____(YYYY)