DUFFERIN & STEELES Dental Office

Last Name ______________________________ **First Name** ______________________________
Date of Birth: ________ / ________ / ________
Month Day Yr
Nickname: ______________________________
Address: ______________________________ City: ______________________________
Postal Code: ______________________________ Tel: ______________________________
Email Address: ______________________________ Work #: ______________________________
Cell #: ______________________________

Emergency Contact: ______________________________ Telephone: ______________________________
Relationship: ______________________________
Family Doctor Name: ______________________________ Telephone: ______________________________
Previous Dentist: ______________________________ Telephone: ______________________________
Who referred you to our office? ______________________________

Financial Information
Preferred Method of Payment: **( )** Cash/Debit **( )** Cheque **( )** MasterCard/Visa

Drivers License #: ______________________________ Expiration Date: ______________________________
Credit Card #: ______________________________ Expiration Date: ______________________________

Insurance Information: (if you have dual insurance, please present both cards to receptionist)
Name of insured: ______________________________ Date of Birth: ______________________________
Insurance company: ______________________________ Policy/Group: ______________________________
Employer name: ______________________________ Certificate/ID#: ______________________________

Secondary Insurance:
Name of insured: ______________________________ Date of Birth: ______________________________
Insurance company: ______________________________ Policy/Group: ______________________________
Employer name: ______________________________ Certificate/ID#: ______________________________

Authorization and Release

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE; THE ABOVE & FOLLOWING QUESTIONS HAVE BEEN ACCURATELY ANSWERED.
I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.
I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO MY CHILD OR MYSELF DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS.
I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAT THE ATUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDANTS.

Privacy Act: Information

The enclosed information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality.
I have reviewed the information that explains how Dufferin Steeles Dental office will use my personal information, and the steps the office is taking to protect my information. I know that Dufferin Steeles Dental office has a Privacy code, and I can ask to see the code at any time. I AGREE that Dr. Ira Schecter and Dr. Michael Schecter, hygienists, and staff can collect, use and disclose personal information about myself as set out above in the information about the office's privacy policies.

Signature: ______________________________ Date: ______________________________
( ) Patient **( )** Parent/Guardian

Witness Signature: ______________________________

Dental History

Reason for today visit: ( ) Emergency ( ) Exam ( ) Other ____________________
How frequently did you see a dentist: ( ) 3-6 months ( ) Annually ( ) Other ____________________
Date of last dental visit: ____________________ Last x-rays: ____________________
How often do you brush your teeth? ____________________
Floss: ( ) **YES**, how often: ____________ ( ) **NO**, why ____________________
Type of toothpaste used ____________________
Do you use a water jet? ____________________ Mouth rinse? (name) ____________________
Is your drinking water fluoridated? ____________ Do you use anti-bacterial rinse? (name) ____________________

Is there anything you would change about the appearance of your teeth? ____________________
____

Have you ever had an unpleasant dental experience? (if yes, please specify) ____________________

Please check appropriate boxes:

	YES	**NO**
Do your gums bleed while brushing/flossing? ____________________	( )	( )
Do you chew your lips/ tongue/ pencil /nails? (please circle) ____________________	( )	( )
Are your teeth sensitive to hot or cold liquids/food? ____________________	( )	( )
Are your teeth sensitive to sweets or sour liquids/foods? ____________________	( )	( )
Do you feel pain to any of your teeth? ____________________	( )	( )
Do you have any sores or lumps or swelling in or near your mouth? ____________	( )	( )
Have you had any head, neck or jaw injuries- or major surgery? ____________	( )	( )

Do you have frequent headaches? ( ) YES Clench /Grind ( ) YES

Have you ever experienced any of the following problems in your jaw?
( ) Clicking ( ) Pain (joint, ear side of face)
( ) Difficulty Opening/ Closing ( ) Difficulty chewing

Do you notice any loosening of your teeth? ____________________	( )	( )
Do you have a bad taste in your mouth? ____________________	( )	( )
Does food tend to become caught between your teeth? ____________________	( )	( )
Have you ever had periodontal surgery? ____________________	( )	( )
Have you ever worn a bite plate or other dental appliance? ____________________	( )	( )
Do you were dentures / partials? YES ( ) If yes date of placement? ____________		
Have you ever had any difficult extractions in the past? ____________________	( )	( )
Have you ever had any prolonged bleeding following extractions? ____________	( )	( )
Have you ever received oral hygiene instructions regarding the care of your teeth/gums?	( )	( )

Nutritional

	YES	NO
Are you on regular medication including supplements or vitamins? ____________	( )	( )
Have you ever received nutritional counseling? ____________________	( )	( )
What guidelines do you use for nutrition: ____________________		
Have you had biocompatibility testing of dental materials? Date: ____________	( )	( )

Are you seeing/or have you seen within the last year any of the following:
( ) Naturopath ( ) Nutritionist ( ) Chiropractor ( ) Physiotherapist ( ) Osteopath
( ) Homeopath ( ) Other ____________________

How much sun do you get? ____________________

Circle appropriate answer: (leave blank if you do not understand the question)

YES **NO** Is your general health good?
YES **NO** Has there been a change in your health within the last year?

YES **NO** Have you been hospitalized or had a serious illness in the last three years?
If YES, why? ____

YES **NO** Are you currently being treated by a physician /specialist**? If YES** for what?
____

Date of last physical exam? ____________________________

Please check if you have experienced:

( ) Chest Pain (Angina)
( ) Ringing in ears
( ) Shortness of breath
( ) Recent weight Loss, fever, night sweats
( ) Persistent Cough, coughing up blood
( ) Bleeding problems, bruising easily
( ) Frequent vomiting, nausea
( ) Difficulty Swallowing
( ) Diarrhea, constipation, blood in stools
( ) Dizziness
( ) Dry Mouth
( ) Headaches
( ) Fainting Spells
( ) Blurred vision
( ) Swollen Ankles
( ) Excessive thirst
( ) Frequent Urination
( ) Difficulty urinating, blood in urine
( ) Sinus Problems
( ) Joint Pain, stiffness
( ) Seizure
( ) Jaundice
( ) Other _______________

Please check if you have or have you had:

( ) Heart Disease
( ) Heart Attack, heart defects
( ) Heart Murmurs
( ) Stroke, hardening of arteries
( ) High /Low blood pressure
( ) Asthma, TB, emphysema, lung disease
( ) Hepatitis (a) (b)(c) other liver disease
( ) Stomach problems, ulcers
( ) Family history of diabetes, heart problems, tumors
( ) HIV
( ) Tumors Cancer
( ) Arthritis Rheumatism
( ) Skin diseases
( ) Rheumatic /Scarlet Fever
( ) Diabetes
( ) Herpes
( ) Kidney, bladder disease
( ) Thyroid Adrenal Disease
( ) Anemia
( ) Eye Diseases
( ) Other _______________

Do you have or have you had an adverse reaction / allergy to:

( ) Aspirin
( ) Latex
( ) Sulfonamides
( ) Penicillin
( ) Local Anesthetic
( ) Metal
( ) Antibiotic
( ) Codeine
( ) Barbiturates (Sleeping pills)
( ) Food allergy ________________________________
( ) Other____

Do you have or have you had:

( ) Radiation Treatment
( ) Chemotherapy
( ) Blood transfusion
( ) Pacemaker
( ) Artificial Joint
( ) Prosthetic heart valve

Are you taking: (if yes, specify **dosage/frequency?**)

( ) Recreational drugs? ______________________________
( ) Drugs, medications, (including over the counter medicines, natural remedies)?
( ) Tobacco? ____________________________________
( ) Alcohol? ____________________________________

Name/Medication Dosage/Strength	Dosage/Strength	Name/Medication

Women Only:

YES **NO** Are you or could you be pregnant? Due Date_______________
YES **NO** Are you taking the birth control pill?
YES **NO** Are you nursing?
YES **NO** Reached menopause?