ATLANTIC DENTAL
Halifax

# PATIENT INFORMATION

*Your cooperation in filling out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care.

Name Mr. Mrs. Ms. Dr. _____
*Last* *First* *Middle*

Age _____ Sex _____ Date of Birth _____
*Day* *Mo.* *Year*

Address _____
*Street* *City* *Prov. (State) Postal Code (Zip)*

Home Phone _____ Cell Phone _____

Email _____

Dental Insurance. Yes No Name of Company _____

Ins. Policy No. _____ % Covered _____

Ins. Certificate No: _____

Employed By _____ Bus. Phone _____

Health card number _____

Family Physician _____ Phone No. _____

Previous Dentist _____

Whom may we thank for referring you? _____

In case of emergency notify: Name _____

Address _____

Relationship _____ Telephone _____

## Office Policy

**Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it will be necessary to charge for the time lost.**

**Office policy is that services are paid for at each visit as they are performed.**

## Confidential Health History

What is your reason for booking this appointment?

_____

When was your last dental visit? _____

| | | Please Circle | |
|---|---|---|---|
| 1. | Do you have any dental pain at this time? | Yes | No |
| 2. | Are you aware of any broken teeth or fillings? | Yes | No |
| 3. | Do you have sensitive teeth? All teeth or specific areas? | Yes | No |
| 4. | Are you aware of any lump or swelling in your mouth? | Yes | No |
| 5. | Do your gums feel tender or swollen? | Yes | No |
| 6. | Do you have bleeding gums? | Yes | No |
| 7. | Do you have bad breath or a bad taste in your mouth? | Yes | No |
| 8. | Do you have loose teeth? | Yes | No |
| 9. | Do you get migraines or headaches? | Yes | No |
| 10. | Do you get sinus pain or pressure? | Yes | No |
| 11. | Do you get neck or back pain? | Yes | No |
| 12. | Do you have popping or clicking in your jaw joints? | Yes | No |
| 13. | Do you get jaw joint (TMJ) pain? | Yes | No |
| 14. | Do you get earaches? | Yes | No |
| 15. | Are your teeth crowded, crooked or spaced? | Yes | No |
| 16. | Would you like anything about your smile changed or improved? | Yes | No |
| 17. | Do you feel your teeth are not as white or bright as they could be? | Yes | No |

18. Are you taking any medications? (if yes, please list) Yes No

_____

19. Do you have any allergies? (products or medications) Yes No

If yes, please list_____

20. Do you have a bleeding disorder, or do you bleed or bruise easily? Yes No
21. Do you have any liver disease? Yes No
22. Do you have any lung disease or difficulty breathing? Yes No
23. Are you aware of any snoring? Yes No
24. Do you ever gasp for breath in your sleep? Yes No
25. Have you taken cortisone or steroids (please circle lotion or pill) Yes No
26. Have you ever had heart surgery or heart disease? Yes No
27. Do you have any conditions involving your heart or blood pressure? Yes No
28. Do you have any kidney disease? Yes No
    If yes, do you have a shunt appliance? Yes No
29. Have you had cancer, chemotherapy, or radiation treatment? Yes No
    If yes, how long ago? _____
30. Have you ever had rheumatic fever? Yes No
    If yes, was there any heart damage? Yes No
31. Do you have AIDS or HIV? Yes No
32. Have you had an organ transplant? Yes No
    If yes, what organ? _____
    Are you taking anti-rejection medication? Yes No
33. Have you had a joint replacement? Yes No
    If yes, was it less than two years ago? Yes No
34. Are you diabetic? Yes No
    If yes, do you take pills or insulin? _____
35. Other than the above, have you been hospitalized and was surgery performed? Yes No
36. Have you had any other serious illness? Yes No
37. Do you have any other medical conditions? Yes No

38. Have you taken any of the following medications? (please circle)

Zometa, Didronel, Fosamax, Skelid, Actonel, Aredia, Boniva, Bonefos

Women: Are you pregnant? If yes, what month _____ Yes No
Are you breast feeding? Yes No

## Consent For Treatment

I consent to the performing of the dental procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures. I have reviewed the Privacy Statement for Patients that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that Atlantic Dental Centre can collect, use and disclose my personal information as set out in the office's privacy policy.

_____ _____

**Signature of patient or parent/guardian** **Date**

### Electronic Claims Submission Signature on File (CDAnet)

I authorize release, to my dental benefit plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist.

_____ _____

**Signature of Patient or parent/guardian** **Date**