Woodbridge Vaughan dental

Patient Information

Mr./Mrs./Ms/ Last Name: _____ First Name: _____

Birthdate (D/M/Y): _____ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Address: _____City: _____ Postal Code: _____

Home tel. # _____ Work tel. #: _____ Ext._____

Cell tel. #:_____ Email:_____

Preferred method of contact: ○ Home ○ Work ○ Cell ○ Email ○ Text Preferred appt.day/time _____

Emergency contact: _____Relationship:_____ Tel. #_____

Referred by: Sign / Social Media / Google / Patient _____ ○ Other_____

(Please circle one)

Dental Insurance Information

Primary Carrier:

Policy holder's Last name: _____ First Name: _____

Relationship to patient:_____ Birthdate (D/M/Y): _____

Employer: _____ Insurance company: _____

Group/Policy #:_____ ID/Certificate #: _____

Secondary Carrier

Policy holder's Last name: _____ First Name: _____

Relationship to patient:_____ Birthdate (D/M/Y): _____

Employer: _____ Insurance company:_ _____

Group/Policy #:_____ ID/Certificate #: _____

On occasion, our office will distribute newsletters by email which may include valuable dental health information, important updates regarding *Woodbridge Vaughan Dental* and fabulous promotions. We also use your email address to confirm your dental appointments. If you have not included this information previously, please provide it now.

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Dental History

1. What is your primary concern with your teeth/smile? _____

_____

2: Are you happy with the appearance of your teeth/smile? _____

_____

3. How can we help you smile more ? _____

_____

4. Are you anxious about having dental treatment? If so, what is your biggest concern? _____

_____

_____

Do you have, or have you had, any of the following?

Discomfort or pain?	○
Tooth sensitivity?	○
Headaches, earaches or neck aches?	○
Problems with your jaw joints?	○
Clenching or grinding of your teeth?	○
Problems with your bite?	○
Serious trouble associated with previous dental treatment?	○

Please explain:

_____

_____

_____

Additional Information

Is there anything in your medical and dental history that we have not specifically asked about that we should be made aware of? If so, please explain:

_____

_____

_____

Thank you for choosing *Woodbridge Vaughan Dental* for your dental care needs. Please read through the following page and sign where indicated, acknowledging that you understand our policies and agree to comply with them. We welcome your questions and comments and are committed to providing exceptional dental care to all our patients. We appreciate the confidence you place in us.

Dental Insurance

As a courtesy, we accept most dental insurance benefits and payments are assigned directly to the office. Any charges not paid for by your carrier, is due at the time of service. Your co-insurance payment is calculated by information you have provided and/or information received from your dental carrier. Please note that your dental insurance policy is a contract between you, the employer and your insurance company; we are not a party to that contract and are not provided with any detailed information or updates. Any estimate(s) pre-approved by your carrier is NOT a guarantee of payment. Any claim not paid by your insurance carrier within 60 days will be billed to you.

Appointment Cancellations

Please provide 2 business days notice when cancelling or changing an appointment. Failure to provide such notice compromises the service that we deliver to our patients. **If inadequate notice has been provided, a $75.00 cancellation fee will apply**. Our answering machine does not accept cancellations. You must speak to a member of our team to cancel or change your appointment.

Authorization & Release

I authorize and request the performance of dental services for myself or for the listed dependant. I will be informed of the need for additional treatment and its fee.

I authorize and request my insurance company to pay *Woodbridge Vaughan Dental* directly any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the total claim amount for services. I agree to be responsible for payment of all the services rendered on my behalf or my dependants.

I authorize *Woodbridge Vaughan Dental* to submit my dental claims, electronically, to my insurance company on my behalf and obtain necessary insurance information as is pertinent to my treatment.

I give consent to any advisable and necessary dental procedure, medications or anesthetic to be administered by the attending dentist or by her supervised staff for diagnostic purposes or dental treatment.

Records may include study models, photography and/or x-rays, which may be used for dental education, used in dental publications and/or social media.

Accounts 90+ days in arrears will incur a 2% service fee and will be forwarded to an external collecting agency.

To my knowledge, I have given an accurate medical and dental history.

I have read the above and understand fully, the policies as outlined.

Signature of Patient/Guardian: _____

Date :_____

Signature of doctor: _____