Beamstown DENTAL GROUP

DATE:

Welcome to Our Office

Your medical history is very important to us. In order that we may provide you with the best possible dental services, please answer all questions completely and accurately as incorrect information may compromise your treatment. This Medical History Form will become a part of your dental treatment record and is considered "Confidential."

Patient Information

Last Name _____ First Name _____

Address _____

City _____ Province _____ Postal Code_____

Phone (____)_____ Email_____

Birth Date_____ Occupation _____

Do you have dental insurance? (circle) *Yes* *No*

How did you hear about us? _____

Dental History

1. What is the reason for today's visit?(circle) *Emergency* *Examination* *Other*_____
   _____
2. How frequently do you see a Dentist?(circle) *3 months* *6 months* *9 months* *Annually*
3. When was your last dental visit?_____ Last X-Ray?_____
4. How often do you brush per day?_____ Floss?_____
5. Are your teeth sensitive to? (circle all that apply) *Sweets* *Cold* *Heat* *Pressure*
6. Do your gums bleed when (circle all that apply) *Brushing* *Flossing* *Never*
7. Have you ever been told you have bad breath?(circle) *Yes* *No*
8. Have you ever had any pain in your jaw joint (clicking, popping)? (circle) *Yes* *No*
9. Are your teeth loose? (circle) *Yes* *No*
10. Do you grind or clench your teeth? (circle) *Yes* *No*
11. Does food catch between your teeth? (circle) *Yes* *No*
12. Have you ever had local anaesthetic (freezing)? (circle) *Yes* *No*
    Any complications? *Yes* *No* *Specify*_____
13. Have you ever had any problems with previous dental treatments? (circle) *Yes* *No*
    *Specify*_____
14. Are you happy with your smile/satisfied with your teeth? (circle) *Yes* *No*
    If no, please explain:_____
15. What would you change about the present condition of your mouth? _____
    _____

Medical History

1. Are you currently under the care of a physician? (circle) *Yes* *No*
   Reason for last visit?_____ Date:_____
   Physician's Name:_____ Phone: (____)_____
   Address:_____
2. Have you ever had a serious illness, operation, or been hospitalized?(circle) *Yes* *No*
   If so, please explain:_____
3. Has there been any change in your health in the last (2) years? (circle) *Yes* *No*
   If so, please explain:_____
4. Have you ever had an allergic reaction? To: (circle) *Medication* *Food* *Latex Products*
   Other:_____
5. Have you ever been treated for*: (circle all that apply)*

Anxiety	Depression	Hepatitis	Mental/nervous Disorder
Arthritis	Diabetes	High Cholesterol	Rheumatic Fever
Asthma	Dry Mouth	HIV Positive	Stroke
Bleeding/Clotting Disorder	Epilepsy or Seizures	Hyperglycemia	Tuberculosis
Blood Pressure: High or Low	Fibromyalgia	Hypoglycemia	Other: _____
Cancer	Heart Condition	Joint Replacement	

6. Do you now or have you ever used tobacco? (circle) *Yes* *No*
7. For women: a. Are you pregnant or do you think you may be pregnant? (circle) *Yes* *No*
   b. Are you taking birth control pills? (circle) *Yes* *No*

Current Medication(s): Prescribed and Over-the-Counter

	Name of Medication	Dose	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Emergency contact information

Name _____ Relationship _____
Phone (____)_____

Patient Signature _____ Date_____

If you have completed this form for another person, please print your name and sign below along with your relationship to the patient.

Print_____ Relationship_____

Signature_____ Date_____

Beamstown DENTAL GROUP

Consent for Dental Treatment

This is to certify that I consent to performing of dental procedures agreed to be necessary or advisable, including the use of local anaesthetic. I understand that any treatment needed will be fully discussed with me by the dentist prior to the beginning of treatment, including all treatment options. I understand that no treatment is always an option. I also understand that any treatment done, including but not limited to, fillings and crowns, while intended to save the tooth, may result in tooth death, which may further result in the need for a root canal or extraction. I will also assume responsibility for the fees associated with all dental procedures performed.

_____	_____	_____
Signature of patient, parent or guardian	Print Name	Date

Consent for Collection and Release of Information

Contact Information

We are committed to protecting the privacy of our patients` personal information. We collect contact information from our patients for the purposes of opening/updating patient files, to confirm dental appointments, send recall notices, and collect payment for outstanding balances owing.

Medical Information

We collect medical information for the purpose of diagnosing and providing responsible and informed dental treatment. This information may be disclosed to third party health benefit providers and insurance companies, other dentists or dental specialists, or physicians or other medical specialists as deemed appropriate by the dentist for the purposes of consultation or referrals.

Dental History

We collect dental history so our office can provide continuing dental treatment for the patient, as well as for possible consultation or referral to dental specialists if needed. We may request past dental records, including radiographs, be forwarded to our office from previous dentists.

Access to Information

If we ever consider selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to our office records, including patient information. If this occurs, steps will be taken to ensure the prospective purchaser safeguards all personal information. Also, dentists are regulated by the Ontario Dental Association and College, which may inspect our records from time to time as part of its regulatory activities in the public interest.

Insurance Submission

We send dental insurance claims to participating insurance companies electronically.

I consent to the collection, use and disclosure of my person information as set out above.

_____	_____	_____
Signature of patient, parent or guardian	Print Name	Date