

WELCOME

TO DIAMOND DENTAL

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to obtain the healthy teeth and attractive smile you want and deserve.

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. PLEASE PRINT.

Date: _____

REGISTRATION INFORMATION

The patient is an: Adult Adult under guardianship Child Name of Guardian: _____

Name: _____ Dr. Mr. Mrs. Ms. Miss
(last) (first) (initial)

Address: _____
(street) (apt. #) (city) (province) (postal code)

Reason for today's visit? Examination Other _____

A.H.C.#: _____ Preferred appt. time? _____

Home Phone: () _____ Bus Phone: () _____ Ext. _____ May we call you at work?

Email Address: _____

PERSONAL INFORMATION

Prefers to be called: _____ Occupation: _____

Date of Birth: M ___ D ___ Y ___ Age: ___ Sex: ___ Marital Status: ___ Name of Spouse: _____

Are other family members patients at our office? Yes Names: _____

How did you hear about our office? Friend/Relative Yellow Pages Advertising Other _____

Whom may we thank for referring you? _____

MEDICAL PRIORITY

Family Physician _____ Phone: () _____

Medical Specialist: _____ Phone: () _____
(if presently under care)

In case of emergency, please contact: _____ Phone: () _____

FINANCIAL INFORMATION

Person responsible for account: Self Spouse Other _____ **Please complete all information if different than above.**

Name: _____ Phone: () _____
(last) (first) (initial)

Address: _____
(street) (apt. #) (city) (province) (postal code)

Employed by: _____ Phone: () _____

PATIENT REGISTRATION

DENTAL HISTORY

DENTAL HISTORY

Please ✓ YES or NO to each question. If unsure of a question, please consult with the dentist or receptionist.

Is there a dental problem you would like treated immediately? Yes Problem: _____ No **YES NO**

Are there any other dental conditions that concern you at present? Yes Condition: _____ No

Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays? _____

1. Have you been seeing a dentist regularly? _____

2. Have you ever had any of the following?

	YES	NO		YES	NO
-Periodontal Treatment? (treatment of the gums)	<input type="checkbox"/>	<input type="checkbox"/>	-Dentures or Partial Dentures? (circle)	<input type="checkbox"/>	<input type="checkbox"/>
-Orthodontic Treatment? (to straighten or realign teeth)	<input type="checkbox"/>	<input type="checkbox"/>	-Wisdom Teeth Removal?	<input type="checkbox"/>	<input type="checkbox"/>
-A bite plate, night guard or any other appliance?	<input type="checkbox"/>	<input type="checkbox"/>	-Root Canal Treatment?	<input type="checkbox"/>	<input type="checkbox"/>
-Crowns or Bridges?	<input type="checkbox"/>	<input type="checkbox"/>			

3. Are there any growths or sore spots in your mouth? _____

4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? _____

5. Have you noticed any loose teeth, or, have any of your teeth shifted? _____

6. Does food catch between your teeth? _____

7. Are any of your teeth sensitive to heat, cold, sweets or pressure? (circle) _____

8. Have you ever experienced any of the following jaw problems:

- Popping/clicking in your jaw joints? _____
- Pain in your jaw joints, around your ear, or side of your face? _____
- Difficulty in opening or closing? _____
- Pain when teeth are clenched? _____
- Pain or difficulty while chewing? _____

9. Do you have any of the following habits?

- Clenching or grinding your teeth while awake or asleep? _____
- Biting your cheeks or lips? _____
- Mouth breathing while awake or asleep? _____
- Gag reflex: slight _____ moderate _____ severe _____

10. Are you missing any teeth? Yes No If so, have they been replaced? Yes No If not, would you like them replaced? Yes No

11. Are you unhappy with the appearance of your teeth? _____
and, What would you like to see changed? _____

12. Do you have any concerns about halitosis (bad breath)? _____

13. Are you interested in any of the following? (Please ✓)

<input type="checkbox"/> Teeth whitening or bleaching	<input type="checkbox"/> Cosmetic dentistry
<input type="checkbox"/> Treatment of bad breath (halitosis)	<input type="checkbox"/> Digital imaging (computer modification of a digital photograph of your teeth to show you what changes would look like)
<input type="checkbox"/> Orthodontic treatment	

14. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? _____

OFFICE POLICY

APPOINTMENTS

Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore at least 24 HOURS NOTICE **MUST** be given if cancellation is absolutely necessary.

PAYMENT OF FEES

- This office is willing to accept direct payment from your dental plan for services which your plan covers.
- If your dental plan does not cover the full cost of your treatment, you will be responsible for any difference between the amount paid by your plan and the amount charged.
- Your portion is then due and payable on the day of your appointment unless other financial arrangements have been made. There will be a 1.5% administration fee per month on all accounts over 30 days old.
- You are responsible for providing the necessary information in order for us to direct bill your insurance company as well as informing us of any changes in this information.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information.

CONSENT

I, the undersigned, hereby authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and consent to the use of local anaesthetic agents. I understand the above statements regarding the payment of fees and accept the responsibility for payment for Dental Services provided for myself or my dependents, due and payable when services are rendered unless other financial arrangements have been made.

Patient Signature: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to Patient: _____