PATIENT INFORMATION

DR. JENNIFER MATTHEWS & DR. HARPRIT KLER

PATIENT INFORMATION

Patient's Name: ☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Dr. ____________________
Surname Given Names

Birthdate: _____/_____/_____ (Month Day Year) **Age:**______ **Sex: M F** (Please Circle One) **S.I.N.** ____________________ (Social Insurance Number)

Home Address:____________________

City:____________________ **Prov.**__________ **Postal Code**__________

Home Phone:__________ **Cel Phone&/or Pgr:**__________ **Work Phone:**__________

E-Mail Address:__________ **How often do you check your e-mail?**__________

Employer:__________ **Occupation:**__________

How did you hear about our office? Referred by:__________ **Other:**__________

In case of emergency please notify:__________ **Phone:**__________

INSURANCE INFORMATION

PLAN #1 - Insurance Carrier:__________ **Group #**__________ **Cert/Id #**__________
Basic__________**% Prosth**__________**%Crown/Bridge**__________**%Ortho**__________**%**
Primary Plan Member Information: Name__________ **Date of Birth**__________
(if not self)

PLAN #2 - Insurance Carrier:__________ **Group #**__________ **Cert/Id #**__________
Basic__________**% Prosth**__________**%Crown/Bridge**__________**%Ortho**__________**%**
Primary Plan Member Information: Name__________ **Date of Birth**__________
(if not self)

To electronically submit claims to your dental insurance, the Canadian Dental Association requires the following authorizations:

I authorize release, to my dental plans administrator and the CDA, information contained in claims submitted electronically.

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Jennifer Matthews & Dr. Harprit Kler and authorize payment directly to them.

These authorizations shall continue in effect until the undersigned revokes the same.

*Date*__________ *Signature of patient, parent or guardian*__________

I, the undersigned, hereby certify that all information given to this office is true. I understand that it will be kept strictly confidential.
I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetics.
I understand that I will be charged for missed appointments and for cancellations with less than 24 hours notice.
I am also aware, that although this office has agreed to deal with my dental plan, any claims made on my behalf which have not been paid within 60 days become my responsibility.

Patient's signature____________________ ***Date:***__________

Person responsible for account:____________________ (Please print name) **Relationship:**__________

Signature of parent or person responsible for the account____________________

HEALTH HISTORY

Medical History (this information will remain confidential)

Patient Name:________________________ D.O.B. ____________
Family Doctor:________________________
His/Her Telephone number: (________) ____________

1. Are you presently under the care of a physician? **YES**☐ **NO**☐
   If yes, please explain________________________
2. Have you ever been hospitalized? **YES**☐ **NO**☐
   If yes, please explain________________________
3. Are your taking any drugs or medication at this time? **YES**☐ **NO**☐
   If yes, what drugs and why? ________________________

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4. Have you ever had any adverse effect to any of the following: Antibiotic - Penicillin☐, Sulfonamide☐, Aspirin☐; Codeine☐; Barbiturates (sleeping pills)☐; Darvon ☐; Local Anaesthetic ☐; Other☐ ____________ ; NONE☐.
5. Have you ever been warned against using any other medications? **YES**☐ **NO**☐ If yes, why________
6. Have you ever taken prolonged medical or non-medical drugs? **YES**☐ **NO**☐ If yes, which ________
7. Do you suffer from any allergies (hay fever, latex, etc)? **YES**☐ **NO**☐ If yes, what ________
8. Do you bruise easily or have prolonged bleeding? **YES**☐ **NO**☐
9. Do you smoke? **YES**☐ **NO**☐ If yes, how much per day? ________
10. Do you use smokeless (chewing) tobacco? **YES**☐ **NO**☐ If yes, how much per day?________
11. Have you ever fainted, had shortness of breath or chest pains? **YES**☐ **NO**☐
12. **WOMEN** Are you pregnant? **YES**☐ **NO**☐ Using birth control? **YES**☐ **NO**☐ Reached menopause? **YES**☐ **NO**☐
13. Do you have or have you ever had any of the following? Please ✓ appropriate boxes.

☐ A.I.D.S.	☐ Cancer	☐ Heart disease/attack	☐ Jaundice	☐ Rheumatic/Scarlet fever
☐ Anemia	☐ Circulation problems	☐ Heart murmur	☐ Kidney disease	☐ Sickle Cell disease
☐ Angina Pectoris	☐ Congenital heart lesions	☐ Heart pacemaker/surgery	☐ Liver disease	☐ Sinus trouble
☐ Anorexia Nervosa	☐ Cortisone/steroid	☐ Heart rhythm disorder	☐ Leukaemia	☐ Stomach/Intestinal prob
☐ Artificial Heart Valve	☐ Diabetes	☐ Hepatitis A/B/C	☐ Lung Disease	☐ Stroke
☐ Arthritis/rheumatism	☐ Drug/alcohol dependence	☐ Herpes	☐ Malignant Hypothermia	☐ Thyroid disease
☐ Artificial joints(hips etc)	☐ Emphysema	☐ High/Low Blood Pressure	☐ Mental/nervous disorder	☐ Tuberculosis
☐ Asthma	☐ Epilepsy	☐ H.I.V. Positive	☐ Mitral Valve prolapse	☐ Ulcers
☐ Blood disorders	☐ Glandular disorders	☐ Hodgkin's disease	☐ Organ transplant/implant	☐ Venereal disease
☐ Bronchitis	☐ Glaucoma	☐ Hyper (Hypo) Glycemia	☐ Psychiatric disorders	☐ Other________
☐ Bulimia	☐ Head/Neck injuries	☐ Hypertension	☐ Radiation/Chemotherapy	☐ NONE

14. CHILDREN Have you recently had any other the following (approximate date)?
   ☐ Chicken Pox____________ ☐ Measles____________ ☐ Mumps____________
   ☐ Strep Throat____________ ☐ Tonsillitis____________ ☐ NONE____________

DENTAL HISTORY

1. What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other____________
2. How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Other____________
3. When was your last dental visit?____________ Last X-ray?____________
4. How often do you brush per day?____________ Floss?____________ Use anti-bacterial rinse?____________
5. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other____________
6. *Do your gums bleed when:* ☐ Brushing ☐ Flossing ☐ Never
7. Do your gums feel swollen or tender? ☐ Yes ☐ No **8.** Do you have bad breath or a bad taste in your mouth? ☐ Yes ☐ No
9. Do your jaws crack, pop or grate when you open widely? ☐ Yes ☐ No **10.** Do you grind or clench your teeth? ☐ Yes ☐ No
11. Do you have food catch between your teeth? ☐ Yes ☐ No
12. Have you ever had local anaesthetic (freezing)? ☐ Yes ☐ No Any complications? ☐ Yes ☐ No Specify____________
13. Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps ☐ Full or Partial Dentures ☐ Root Canal ☐ Periodontal Surgery (gums) ☐ Orthodontic (braces)
14. Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No Specify____________

GENERAL RELEASE I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both my dependants and myself. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Signature ________ Self ________ Parent/Guardian ________ Print Name ________ Date ________