

PATIENT CONTACT INFORMATION

Mr. Mrs. Ms. Miss Dr.
 First Name: _____ Last Name: _____
 Preferred Name: _____ Date of Birth: _____ (DD/MM/YY) Male Female
 Address: _____ Apt/Unit#: _____
 City: _____ Province: _____ Postal Code: _____
 Home Telephone Number: _____
 May we contact you at your workplace? Yes No
 Work Number: _____ Ext. _____
 May we contact you on your cellular phone? Yes No
 Cell Number: _____
 May we contact you by email? Yes No
 Email Address: _____
 Employer: _____ Position: _____
 Marital Status: Single Married/Common Law Other
 Best way to contact you: Home# Work# Cell# Email
 Best time to contact you: Morning Afternoon Evening
 In case of an emergency - please notify: _____ Telephone Number: _____

REFERRAL INFORMATION

How did you hear about us? (Check all that apply)

Internet Web site/search engine source: _____
 Flyer Flyer description: _____
 Newspaper Newspaper name(s): _____
 Phone Book Publisher: Yellow Pages CanPages PhoneGuide GoldBook
 Radio Station(s): _____
 Event Event name: _____
 Word of Mouth Name of person: _____
 Other Please specify: _____
 Mobile Sign
 New Resident Welcome
 Walked By
 Ad Perks/Work Perks

INSURANCE INFORMATION

Primary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)
 Insurance Policy Holder: Self Parent/Guardian Other _____
 Policy Holder Contact Phone Number: _____ (if different from above)
 Group Policy/Plan Number: _____ I.D./Certificate Number: _____
 Insurance Company Name: _____

Secondary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)
 Insurance Policy Holder: Self Parent/Guardian Other _____
 Policy Holder Contact Phone Number: _____ (if different from above)
 Group Policy/Plan Number: _____ I.D./Certificate Number: _____
 Insurance Company Name: _____

DENTAL HISTORY

Please check any of the following problems that may apply to you.

- Sensitivity (hot, cold and/or sweet)
- Grinding or clenching teeth
- Tooth pain or discomfort while chewing
- Bleeding, swollen or irritated gums
- Headaches, earaches or neck pain
- Loose, tipped or shifting teeth
- Jaw joint pain (clicking/cracking)
- Bad breath or bad taste in your mouth
- Teeth or fillings breaking

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

- Dentures
- Braces
- Partial dentures
- Periodontal (gum) treatments

Please share the following dates:

Your last dental cleaning: ____ / ____

Your last oral cancer screening: ____ / ____

If you could whiten your teeth for a cost anyone could afford, would you do it? Yes No

Do you smoke or use chewing tobacco? Yes No

If yes, how often? _____ For how long? _____

If you could change your smile, you would...

- Make your teeth brighter
- Make your teeth straighter
- Close spaces
- Replace metal fillings with natural, tooth colored fillings
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

On a scale of 1 to 10, with 10 being the highest rating

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

What, if anything, in the past has kept you from having dental treatment? _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Allergies, seasonal | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Snoring/Sleep apnea |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart conditions | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart lesions, congenital | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Phen-fen (1 month+) | <input type="checkbox"/> Venereal diseases |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation (head/neck) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Respiratory problems | |
| <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HPV | <input type="checkbox"/> Rheumatism | |

Do you have any of the following allergies?

- | | | | |
|----------------------------------|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Percodan | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulpha | <input type="checkbox"/> Latex | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Valium | <input type="checkbox"/> Local anesthetic | |

Have you ever had a joint replacement? Yes No If yes, when? _____

Have your physician ever told you to take antibiotics prior to dental procedures? Yes No
If so, why? _____

Are you taking any blood thinners such as Aspirin, Baby Aspirin, Coumadin, Heparin, etc.? Yes No
If yes, please specify _____

Is there anything else you think we should know regarding your medical history? Yes No
If yes, please describe _____

Are you currently under a physician's care? Yes No
If yes, what for? _____

Are you taking any medications? Yes No
If yes, please specify _____

Family physician's name: _____ Physician's phone number: _____

PRIVACY INFORMATION

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. If required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided.

Consent for Collection, Use and Disclosure of Personal Information

I agree that Twilight Dentistry has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

Date: _____ **Signature:** _____