

PERSONAL & HEALTH INFORMATION



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Divisions of Raj Sivendra Dentistry Professional Corporation

PERSONAL INFORMATION

First Name: _____ Last Name: _____

Mr. Mrs. Ms. Miss Master Birth Date: Month _____ Day _____ Year _____

Address: _____ Apt. # _____ City _____ Postal Code _____

Home Phone: () _____ Cellular Phone: () _____

Work Phone: () _____ Ext. # _____ Mine Spouse's Mom's Dad's

Other Phone: () _____ My email address is: _____

The best time to reach me is: Daytime Evening Anytime, at: Home Work Both

I was referred by: Family/Friend Walked in Yellow Pages Internet Newspaper

PERSON RESPONSIBLE FOR ACCOUNT

Myself Spouse Mom Dad Common-Law Partner

First Name: _____ Last Name: _____

Mr. Mrs. Ms. Miss *Complete the following if address is different from above.*

Address: _____ Apt. # _____ City: _____ Postal Code: _____

Home Phone: () _____ Cellular Phone: () _____

Work Phone: () _____ Ext. # _____ Email: _____

PAYMENT METHOD

Insurance/Benefits Plan Cash Cheque Visa Mastercard Amex

Card #: _____ Expiry Date: _____

ALTERNATE CONTACT PERSON

In case of an emergency, we would like to contact someone with a different address and phone number from yours.

Name: _____ Relationship: _____ Phone: () _____

HEALTH INFORMATION

Physician's Name: _____ Phone: () _____

Have you ever had any of the following diseases or medical problems? Please circle your answer (Yes / Unsure / No).
If "Yes", please specify or list.

- | | | |
|---|--------------------------------|--------------------------------------|
| Y ? N Heart Problems | Y ? N Sickle Cell Anemia | Y ? N Arthritis |
| Y ? N Heart Murmur | Y ? N Chest Pain | Y ? N Glaucoma |
| Y ? N Stroke | Y ? N Lung Problems | Y ? N Diabetes |
| Y ? N Congenital Heart Defect | Y ? N Difficulty Breathing | Y ? N Stomach Ulcers / Colitis |
| Y ? N Rheumatic Fever | Y ? N Emphysema | Y ? N Thyroid Problems |
| Y ? N Pacemaker | Y ? N Bronchitis | Y ? N Epilepsy / Seizures / Fainting |
| Y ? N Artificial Heart Valves | Y ? N Asthma | Y ? N AIDS (or related diseases) |
| Y ? N High Blood Pressure | Y ? N Tuberculosis (TB) | Y ? N Cancer |
| Y ? N Low Blood Pressure | Y ? N Liver Trouble, Hepatitis | Y ? N Chemotherapy Radiation |
| Y ? N Anemia | Y ? N Yellow Jaundice | Y ? N Bleeding Problems |
| Y ? N Hip/Joint Replacement | Y ? N Kidney Problems | Y ? N Headaches, severe/frequent |
| Y ? N Have you had any other medical problems not listed above? If "Yes", please specify. _____ | | |

- Y ? N Are you under the care of a physician? _____
- Y ? N Are you taking any medications now? _____
- Y ? N Have you been told to take antibiotics before dental appointments? _____

- Y ? N Have you been hospitalized in the last 15 years? _____
- Y ? N Have you had any previous surgery? _____
- Y ? N Have you had an elevated temperature under general anaesthesia? _____
- Y ? N *For Females:* Are you pregnant? If "Yes", week #: _____
- Y ? N Have you ever had orthodontics? _____
- Y ? N Do you wear contact lenses? _____
- Y ? N Do you smoke? _____
- Y ? N Are you allergic or sensitive to any medicines or materials? Check off or list.

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Clindamycin | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Metronidazole | <input type="checkbox"/> Codeine | <input type="checkbox"/> Erythromycin | _____ |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Dental Anesthetics | _____ |

INFORMATION, CONSENT & OFFICE POLICIES

I understand that the information I have given is correct to the best of my knowledge. I consent to the performing of dental procedures which have been discussed with me and agreed to be necessary or advisable.

I understand that the payments from my dental benefits may be below the current fees of General Practitioners in Ontario and that I am responsible to the dentist for any portion of the claims not covered by my dental plan. I authorize my insurance claims to be submitted electronically where applicable.

For cash patients, payment is due in full unless prior arrangements have been approved.

We reserve our staff and facilities for you. We kindly ask that you honour your appointment times. Should you need to cancel or change your appointment, we require 2 business days notice, in which case no charge will be made. This will allow us to give the time reserved for you to someone in need.

Thank you for your cooperation.

Signature: _____ Date _____

Notes: _____