BDHC
BLOOR DENTAL HEALTH CENTRE

PATIENT FORM

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: ◯ Male ◯ Female

Registering for a child? ◯ Yes ◯ No

Address: _____

Employer: _____ Occupation:_____

Contact Information

Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone Number:_____

Spouse: _____ Phone Number: _____

Family Doctor: _____ Phone Number:_____

In the event that we must contact you for scheduling changes, etc, please indicate the BEST PHONE NUMBER during business hours to phone you: _____

How did you hear about us?

☐ Internet ☐ Patient Referral ☐ Website ☐ Yellow Pages ☐ Mailer

☐ Other: _____

If you were referred, whom may we thank for their trust in us? Referral Name:_____

Insurance Information

Do you have Dental Insurance? ◯ Yes ◯ No Are you the main Policy Holder? ◯ Yes ◯ No

If no, please provide the name of the policy holder: _____

Group Policy Number: _____ Certificate or ID Number: _____

Policy Holder Date of Birth: _____Insuring Company:_____

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Medical History

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by Doctor/Patient confidentiality. The Dentist will review the questions and explain any that you do not understand. Please complete the entire form.

May we contact you via email with information on services and events?

◯ Yes ◯ No

Is your medical physician or naturopath currently treating you for any reason?

◯ Yes ◯ No ◯ Not Sure/Maybe If yes, please specify: _____

Have you ever been hospitalized for any illnesses or operations?

◯ Yes ◯ No ◯ Not Sure/Maybe

Have you ever had a general anaesthetic? ◯ Yes ◯ No

Do you bruise easily or bleed excessively when cut?

◯ Yes ◯ No ◯ Not Sure/Maybe

Are you currently taking any medications either prescribed by a MD or NMD?

◯ Yes ◯ No ◯ Not Sure/Maybe

Have you ever taken cortisone, steroids, anti-depressants, blood thinners or thyroid medications?

◯ Yes ◯ No ◯ Not Sure/Maybe

Do you smoke? ◯ Yes ◯ No If yes, how many per day? _____

Women, are you currently pregnant? ◯ Yes ◯ No

Do you have, or have ever had any of the following? Please check

☐ Heart Disease	☐ Hepatitis	☐ Diabetes
☐ Pacemaker or Artificial Valves	☐ Thyroid Problems	☐ Arthritis
☐ Radiation Therapy	☐ Backaches	☐ High Blood Pressure
☐ Blood Disorders/Anemia	☐ Lung or Breathing Problems	☐ Asthma / Shortness of Breath
☐ Stomach/Intestinal Problems	☐ Artificial Joint Replacement	☐ Tumors or Cancer
☐ Headaches	☐ Heart Murmur	☐ Rheumatic Fever
☐ Liver Problems	☐ Kidney Problems	☐ Tuberculosis
☐ Epilepsy or Seizures	☐ STD's, HIV – which one: _____	

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Do you wake up feeling refreshed after a full night's sleep? ◯ Yes ◯ No

Do you snore? ◯ Yes ◯ No ◯ Not Sure/Maybe

Are you allergic to any medication or drugs? ◯ Yes ◯ No

Do you have any allergies? ◯ Yes ◯ No ◯ Not Sure/Maybe

If yes, to what? _____

Is there anything else concerning your health the dentist should know?

◯ Yes ◯ No ◯ Not Sure/Maybe

If yes, to what? _____

Dental History

Approximate date of last dental exam and scaling? _____

When was your last dental appointment? _____

Have you ever had any of the following

☐ Fillings/restorations	☐ Nitrous oxide (laughing gas)	☐ Extractions
☐ Orthodontics (braces)	☐ Regular cleanings	☐ Caps or crowns
☐ Root Canal Therapy	☐ Dental Implant	☐ Recent Dental X-Rays
☐ Periodontics (gum treatment)	☐ Full or Partial Dentures	☐ An injury to your mouth or jaws

Have you ever had a local anesthetic? ◯ Yes ◯ No If yes, any problems? _____

Have you ever had an unfavorable dental experience?

◯ Yes ◯ No ◯ Not Sure/Maybe

If yes, explain: _____

Do you have any fears or anxiety regarding dental visits or treatments? _____

Do you get cold sores or mouth ulcers? ◯ Yes ◯ No If yes, how often? _____

Are you happy with the appearance of your smile? ◯ Yes ◯ No

Are you interested in whitening your teeth? ◯ Yes ◯ No

Is there anything you would like to change about your smile? ◯ Yes ◯ No

Please specify:_____

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Do you presently have or think you may have any of the following:

☐ Loose Teeth ☐ Bad taste in mouth ☐ Cavities

☐ Clicking or Sore jaw ☐ Gum Disease ☐ Earaches or headaches

☐ Sensitive Teeth ☐ Unsightly/Broken fillings ☐ Bleeding Gums

☐ Dead or abscessed teeth (teeth that have had root canal therapy)

In your own words, describe your present dental or needs

Office Philosophy and Policy

- We pledge to provide high quality dentistry in the most comfortable manner possible, with the best equipment, materials and up to date technologies.
- The long term success of our efforts will depend on the patients' willingness to maintain their teeth and prevent any future dental problems.
- We must make a careful diagnosis in an effort to determine a treatment plan that is best for you. This involves a thorough examination often utilizing a prescribed number of x-rays for accuracy.
- All urgent dental problems with be attended to the same day, under normal circumstances.
- Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we require two business days' notice to make any changes or to cancel your reserved appointment otherwise a fee may apply.
- Our office policy is that payment is rendered at the time of service. In certain circumstances, financial arrangements for payment may be considered.
- If you have dental insurance, please provide the office with all the necessary information. Our office will gladly submit your claims for you on line, if your insurance carrier is set up to do so.
- A healthy dentist-patient relationship is based on mutual respect and understanding. Please feel open to discuss with us any aspect of your treatment or fees, at any time.

CONSENT FOR TREATMENT

This is to certify that I consent to the performing of the dental procedures agreed to be necessary and I will assume responsibility for fees associated with those procedures.

Patient Name: _____ Date: _____ Patient Initials: _____