AMHERSTVIEW FAMILY DENTAL

Please take a few minutes to fill out this form. If you have any questions, please don't hesitate to ask. Thank you.

Patient Information Date: _____

Name: _____ Sex: _____ Age: _____ Birthdate: _____

Address: _____ Unit #_____ City_____Postal Code: _____

Marital Status: _____ Phone# _____ Cell# _____

Work#_____ Email: _____

Emergency Name: _____ Phone#: _____ Relationship: _____

How did you learn about Amherstview Family Dental? ☐ Family & Friends ☐ Online Search ☐ Other:

Insurance Information

Name of Policy Holder: _____ Policy Holder's Birthdate: _____

Certificate or I.D Number: _____ Group Policy #: _____

Insurance Company's Name: _____

Medical History

Is your doctor treating you for any reason? If Yes: _____

Are you currently on any medication? Yes or No: ____ Please List Them: _____

Please provide us with your Pharmacy#: _____

Please list your allergies and any allergies to medication: _____

Do you have or experienced any of the following?

☐ AIDS/HIV	☐ Breathing Disorder	☐ Hepatitis A, B, or C
☐ Anemia or Blood Disorders	☐ Cancer	☐ High Blood Pressure
☐ Anxiety	☐ Chronic Bronchitis	☐ Kidney Disorders
☐ Apnea	☐ Depression	☐ Liver Disorders
☐ Arthritis	☐ Diabetes	☐ Long COVID Symptoms
☐ Artificial Joints	☐ Epilepsy	☐ Low Blood Pressure
☐ Artificial Valves or Pacemakers	☐ Fainting/Dizziness	☐ Respiratory Syncytial Virus (RSV)
☐ Asthma	☐ Gastrointestinal (GI) Conditions	☐ Thyroid Disorders
☐ Bipolar Disorder	☐ Heart Disease/Stroke/Disorders	☐ Other: _____

Is there anything else concerning your health that the Dentist should know? _____

Name of Family Doctor: _____ Phone#: _____

Last Check-Up with your Family Doctor? _____

Do you smoke or chew tobacco products? Yes or No _____ Have you had any drug or alcohol dependency? Yes or No _____

Office Use Only: Chart #_____

Dental History

When was your last dental visit (with either a Dentist or a Hygienist)? _____

Have you ever had any of the following?

- ☐ Crowns
- ☐ Extractions
- ☐ Fillings
- ☐ Full or Partial Dentures
- ☐ Injuries to Mouth or Jaw
- ☐ Orthodontics
- ☐ Periodontics (gum treatment)
- ☐ Recent Dental X-Rays
- ☐ Regular Cleanings
- ☐ Root Canals

Have you ever had an unpleasant dental experience? Yes or No _____

Are you anxious or fearful about dental appointments? Yes or No _____

Do you require Nitrous Oxide sedation (Laughing Gas) during your appointments? Yes or No _____

Would you like to improve the general cosmetic appearance of your teeth? Yes or No _____

Would you like to maintain and keep your natural teeth for a lifetime? Yes or No _____

Are you experiencing any of the following?

- ☐ Bad Taste in Your Mouth
- ☐ Bleeding Gums
- ☐ Cavities
- ☐ Clicking Jaw
- ☐ Dead or Abscessed Teeth
- ☐ Earaches
- ☐ Gum Disease
- ☐ Headaches
- ☐ Loose Teeth
- ☐ Sensitive Teeth
- ☐ Sore Jaw
- ☐ Unsightly or Broken Fillings

Office Philosophy and Policy

To determine a treatment plan that is best for your overall Dental Health, we must make a careful diagnosis. This involves a thorough exam, often utilizing a prescribed number of X-rays necessary for accuracy. The long-term success of our efforts will depend on the patient's willingness to maintain their oral health (which includes teeth, jaws, gums, and surrounding tissues) and to prevent any future health problems.

Your appointment time will be reserved especially for you. **If you are unable to keep the appointment, we require 48 hours' notice before your appointment time. Last-minute cancellations or not showing up for your appointment will result in a $60 charge to your account**. Our office policy is that services are paid for at the time the service has been performed along with any outstanding fees on the account.

Regarding Insurance: All patients with dental insurance are responsible for payment to their accounts. We are pleased to offer that if you have insurance, to minimize your expenditure, we will gladly complete any claim forms to assist you in direct billing from your dental benefits, based on the information you provide. Please make sure that you understand any limitations in your insurance contract. We will gladly submit predeterminations for procedures (estimates) to your insurance company, if necessary.

A healthy dentist-patient relationship is based on mutual respect and understanding. Please feel relaxed and open to discussing with us any aspect of your treatment at any time.

Consent for Treatment: This document certifies that I,_____, consent to the performance of dental procedures agreed to be necessary and I will assume responsibility for fees associated with these procedures.

Signature (Patient/Parent/Guardian): _____ **Date:** _____

Office Use Only: Chart #_____ Dentist Signature:_____