PATIENT INFORMATION

Today's Date ____ /____ /____ (D M Y) **Dr.** ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss** ☐ **Date of Birth** ____ /____ /____ (D M Y)

Name: _____
(last) (first) (initial) (prefers to be called)

Address: _____
(street) (city) (prov.) (postal code)

Occupation _____ Age ___ Sex ___ Marital Status _____ Home Phone: ( ) _____

In case of Emergency Phone: _____ Work Phone: ( ) _____ Ext. _____

Cell Phone: ( ) _____ Email: _____

Physician: _____ May we call you at work: Yes ☐ No ☐

School: _____ Full Time Student: Yes ☐ No ☐

DENTAL BENEFITS

Do **YOU** have dental insurance? YES ☐ NO ☐

If YES, Employer _____ Insurance Co. _____

Cert. No. _____ Group/Policy # _____

Do you have dual insurance (spouse or secondary insurance)? YES ☐ NO ☐

If YES, their name _____ Relationship _____ Date of Birth ____ /____ /____ (D M YR)

Employer _____ Insurance Co. _____

Cert. No. _____ Group/Policy # _____ S.I.N. _____

Dental Benefits: I acknowledge that the dentist(s) and staff are willing to assist me in recovering my dental entitlements. I understand that dental insurance is a contract between me the insured and the insurance carrier, not between the insurance carrier and the dentist, and that I am responsible for payment.
EDI Submissions (Electronic Transmission of Claims): Many carriers now accept EDI. This will speed the return of your payment (within 3-6 business days). **I authorize release to my insuring company plan administrator, the information contained in claims submitted electronically.**

Date: _____ Signature: _____

Please answer YES or NO to the following questions

1. Are you being treated for any medical condition at the present or have been treated within 5 years, and if so why and when was your last medical checkup? _____ **YES ❒ NO ❒**
2. Have you ever had a serious operation or been hospitalized? ..... **YES ❒ NO ❒**
3. Are you taking any medications, non-prescription drugs or herbal supplements? Please list: **YES ❒ NO ❒**

   _____
4. Do you have any Allergies to?
   a) medications (i.e.) penicillin, codeine) b) latex c) others _____ **YES ❒ NO ❒**
5. Do you take Aspirin or blood thinners? ..... **YES ❒ NO ❒**
6. Have you ever had an adverse reaction to any medication or injections? ..... **YES ❒ NO ❒**
7. Have you had a joint replacement (i.e. knee or hip) or heart valve replaced? ..... **YES ❒ NO ❒**
8. Have you ever been advised to take antibiotics before dental appointments? ..... **YES ❒ NO ❒**
9. Have you ever had injury or surgery to your head, neck or jaw? ..... **YES ❒ NO ❒**
10. Do you smoke or chew tobacco? ..... **YES ❒ NO ❒**
11. Women - are you pregnant? Delivery date: _____ **YES ❒ NO ❒**

MEDICAL CONDITIONS

Please check off any of the following conditions you presently have or had.

- ❒ Heart Failure
- ❒ High Blood Pressure
- ❒ Low Blood Pressure
- ❒ Heart Murmur
- ❒ Rheumatic Fever
- ❒ Scarlet Fever
- ❒ Congenital Heart Lesion
- ❒ Mitral Valve Prolapse
- ❒ Artificial Heart Valve
- ❒ Heart Pacemaker
- ❒ Heart Surgery
- ❒ Chest Pain
- ❒ Cardiac Arrest
- ❒ Angina Pectoris
- ❒ Shortness of Breath
- ❒ Swelling of Feet/ Ankles/Hands
- ❒ Fainting or Dizziness
- ❒ Stroke
- ❒ Diabetes or Hyperglycemia
- ❒ Kidney Trouble
- ❒ Ulcers
- ❒ Anemia
- ❒ Artificial Joints/Hips
- ❒ Asthma
- ❒ Hay Fever
- ❒ Sinus Trouble
- ❒ Emphysema
- ❒ Frequent Cough
- ❒ Lung Disease
- ❒ Tuberculosis
- ❒ Liver Disease
- ❒ Hepatitis A (intec.)
- ❒ Hepatitis B or C
- ❒ Yellow Jaundice
- ❒ Venereal Disease
- ❒ Cancer
- ❒ Thyroid Disease
- ❒ Chemotherapy/ Radiation
- ❒ Arthritis/Gout
- ❒ Rheumatism
- ❒ Pain in Jaw Joints
- ❒ Cortisone Medicine
- ❒ Glaucoma
- ❒ Epilepsy or Seizures
- ❒ Nervousness
- ❒ Psychiatric Care
- ❒ Drug or Alcohol Addiction
- ❒ Blood Transfusion
- ❒ Hemophilia
- ❒ AIDS (HIV Positive)
- ❒ Cold Sores
- ❒ Fever Blisters
- ❒ Herpes
- ❒ Bruise Easily
- ❒ Sickle Cell Anemia

Please list in detail any other serious illness not shown above which you have or may have had: _____

_____

PATIENT CONSENT FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

The information you have read explains how our office uses your information and the steps our office uses to protect this information. Our office has a privacy code that is available to you. Dr. B. Casson acts as the Privacy Information Officer.

I agree that Dr. B. Casson can collect, use and disclose this personal information about _____ (Patient's name) as set out in the information I have read about the office's privacy policy.

_____ Date _____

Signature

_____

Witness

ALL PATIENTS

I have read, understood and completed the above history to the best of my knowledge.

_____ _____

Signature Date

I consent to my personal physician and pharmacist being contacted if necessary.

_____ _____

Signature Date

I acknowledge I am required to provide 24 hours notice (1 business day) to reschedule or cancel an appointment. The fee for appointments cancelled without appropriate notice is $40.

_____ _____

Signature Date