Authorization

I have reviewed and understand that these questions directly relate to the quality of dental care I can expect to receive in this office, and I have not knowingly withheld any information that could complicate my treatment.

The above information is strictly confidential and will not be released unless authorized by myself.

I authorize the request/release of any records, radiographs, or other pertinent information directly from other parties involved in my treatment such as medical/dental practitioners and Insurance companies. I will assume responsibility for fees associated with dental treatment rendered at Pickering Square Dental.

Thank you for taking the time to complete this patient information form, and trusting us with your dental care.

_____ _____

Patient Signature Dated

_____ _____

Consent required for children under 18
Guardian/Parent Signature Dated

FOR OFFICE USE ONLY

Office Policies and Procedures:

☐ Accounts ☐ Scan Cards ☐ Hours ☐ S/N C/A Pol. ☐ P/L.

☐ Literacy ☐ Earphones ☐ Pipeida ☐ Coat & Blanket

Our Mission Statement:

The goals of our educated, dedicated preventative team is to take pride in the individual care, skill and comfort that we provide to you, our friends, in a safe, warm and trusting environment.

DR. MARVIN LEAN & ASSOCIATES

Pickering Square Dental Office

1450 Kingston Road, Unit 4
Pickering, Ontario L1V 1C1
Tel: (905) 420-1777
Fax: (905) 420-4056

DR. MARVIN LEAN & ASSOCIATES

Pickering Square Dental Office

We appreciate your efforts in completing this form as accurately as possible. If you have questions we'll be glad to help you. We look forward in helping you achieve optimum oral health and a great smile.

Patient Information

Date: _____ Birth Date: _____ PID #: _____

Last Name: _____ First Name: _____

Street Address: _____

City, Province: _____ Postal Code: _____

Home #: _____ Bus. #: _____ Ext.: _____

Cell/Mobile #: _____ Employer/School: _____

E-mail: _____ S.I.N. #: _____

Emergency Contact Name and Telephone #: _____

If child, Name of person responsible for this account: _____

Who may we thank for referring you to our office: _____

What prompted your visit here today: _____

Is there anything that we need to know about you to ensure that your visits here are positive experiences?

_____

_____

_____

_____

Insurance

If you have dental insurance please complete information (if not insured, please proceed to payment section below)

Primary Insured Name: _____ Relationship to Patient: _____

Insured Employer: _____ Birth Date: _____

Insurance Company: _____ Group #: _____ ID/Cert./SIN #: _____

Do you have secondary benefits: _____

Secondary Insured Name: _____ Relationship to Patient: _____

Insured Employer: _____ Birth Date: _____

Insurance Company: _____ Group #: _____ ID/Cert./SIN #: _____

Claims submitted electronically to insurance require authorization by subscriber:

Signature: _____ Date: _____

Information required if payment made by cheque:

- Driver's Licence #: _____
- Social Insurance Number: _____
- Major Credit Card #: _____
- Place of Employment: _____

If Patient a child:

Parent/Guardian: _____

Address: _____

Tel. #: _____

Birth Date: _____

Dental History

Date of last dental visit: _____

Date of last Dental Hygiene appointment: _____

Date of last Dental X-Rays: _____ FMS/PAN: _____ BW's: _____

Previous dentist's tel. # to request records/x-rays if necessary: _____

Date of request: _____ Received: _____ Reviewed: _____

Any previous unpleasant dental experience: _____

Have you ever experienced the following? (check boxes if applicable)

- ❑ Extractions (tooth removal)
- ❑ Dentures, Bridges or Implants (tooth replacements)
- ❑ Periodontal (Gum) treatments or surgery, bleeding from the gums, advised of any specialized periodontal needs
- ❑ Loose teeth or areas where food frequently becomes caught
- ❑ Orthodontics (Braces)
- ❑ Endodontics (Root Canals), Conventional or Surgery
- ❑ Hot or cold sensitivity
- ❑ Crowns (Caps) or Veneers
- ❑ TMJ (jaw joint) problems, wake up with headaches, aware of any clenching or grinding, any difficulty opening or closing, any bite adjustments
- ❑ Unpleasant reaction or experience with anaesthetic (freezing)

Is there any additional information that the dentist should be aware of? _____

_____

Present State of Health and Medical History

Some medications and health conditions affect oral health and complicate dental treatment. Therefore, we must record an accurate health history for your benefit and protection.

Medical Doctor: _____ Address or Tel#: _____

How is your present state of health? _____

_____

ARE YOU BEING TREATED FOR ANY ILLNESS OR CONDITIONS BY A HEALTH PROFESSIONAL? (Physician, Dentist, Physiotherapist, Chiropractor, Naturopath...) ❑ YES ❑ NO

If yes, please explain: _____

_____

Are you taking any prescription or non-prescription medications, vitamins or herbs now? If yes, please list name, dose and frequency:

1. _____ 2. _____

3. _____ 4. _____

**Taking antibiotics can nullify the protection of your birth-control pills for that cycle. Alternate precautions to prevent pregnancy must be used for that cycle.*

Have you stopped taking any medications within the last year? (e.g. steroids, cortisone, prednisone) _____

Do you have any known allergies to drugs/medications? (i.e. penicillin, local anaesthetic, aspirin) ❑ YES ❑ NO

Are you pregnant now? ❑ YES ❑ NO If yes, due date: _____

Do you bruise easily? ❑ YES ❑ NO Do you have chest pain on exertion? ❑ YES ❑ NO

Do you smoke? ❑ YES ❑ NO If yes, how many per day? _____

Do you have stiffness/restriction in movement to your neck or limbs? ❑ YES ❑ NO

*Is there any additional information that the dentist should be aware of? _____

_____

Medical History (continued)

The answers to these questions are essential in providing you with the most thorough dental care.

When was your last medical checkup: _____

If it was for a particular problem, please explain: _____

Please answer the following questions: **Do you presently have or have you ever had any of the following?**	YES	NOT SURE/ MAYBE	NO
• Rheumatic fever	____	____	____
• Heart disease, heart attack, stroke, blood pressure problems, pacemaker	____	____	____
• Heart murmur or mitral valve prolapse	____	____	____
• Immuno-compromising diseases (HIV positive, AIDS, leukaemias, etc.)	____	____	____
• Hepatitis A/B/C, jaundice, liver disease or gastrointestinal disorders	____	____	____
• Chronic cold/canker sores, herpes or venereal diseases	____	____	____
• Significant respiratory diseases (e.g. asthma, emphysema, tuberculosis, COPD, etc.)	____	____	____
• Sinus problems	____	____	____
• Skin rashes	____	____	____
• Glaucoma	____	____	____
• Endocrine disorders (e.g. diabetes)	____	____	____
• Blood disorders, anaemia, bleeding or bruising tendency	____	____	____
• Epilepsy or seizures	____	____	____
• Psychiatric illness, anxiety, depression including any medications	____	____	____
• Fainting or dizzy spells	____	____	____
• Severe headaches	____	____	____
• Surgery involving transplants of organs, joint replacements, or plates with screws	____	____	____
• Thyroid disease	____	____	____
• Nutritional status/eating disorders (e.g. anorexia, bulimia, or major weight changes)	____	____	____
• Cancer, radiation therapy, chemotherapy	____	____	____
• Surgery	____	____	____
• Kidney disease	____	____	____
• Malignant hyperthermia	____	____	____
• Peculiar, adverse or allergic reactions to medications, injections, food, latex, anaesthetic, any known allergies	____	____	____

Hospitalization history: _____

_____

Anything not mentioned above that you would like to share with us: _____

_____

_____

Your Smile

Are you pleased with the appearance of your smile? _____

Are you dissatisfied in any way with your teeth as far as; colour, shape, size or spacing? _____

If you could change anything about your teeth or smile, what would it be? _____

What are your long-term goals regarding the condition of your mouth? _____

_____