



Cedarbrae Dental

Welcome to Cedarbrae Dental. We look forward to getting to know you, your family and friends and caring for your dental health, with the goals of high quality and gentle dentistry in mind. We treat all of our patients in the same manner as we would treat our families and ourselves. We will present you with your diagnosis and treatment options, honestly and openly, to help you make confident choices. We are proud of our safe and friendly environment, dependable and punctual services.

About the Patient

Mr. Mrs. Miss Ms. Dr.

Last name: _____ First name: _____ Preferred name: _____

Birthday: M _____ D _____ Y _____ Marital status _____ Email _____

Home address: _____ City: _____ Province: _____ Postal code: _____

Home phone #: (____) _____ - _____ Work phone #: (____) _____ - _____ ext: _____ Other: (____) _____ - _____

Where and when are the best times to reach you? _____ Occupation: _____

Social Ins. # _____ / _____ / _____ Person responsible for account: _____ Relationship: _____

Emergency contact: _____ Relationship: _____ Phone #: (____) _____ - _____

Whom may we thank for referring you to our practice? _____

Other family members seen by us: _____

<p>Patient is a child <input type="checkbox"/> an adult under guardianship <input type="checkbox"/> Who is with the patient today? _____ Relation _____</p> <p>Mother's name: _____ Work #: (____) _____ - _____</p> <p>Father's name: _____ Work #: (____) _____ - _____</p> <p>Legal guardian: _____ Work #: (____) _____ - _____</p>

Do you have dental insurance? Yes No If so, please give your insurance information to the front desk.

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? Y N Please explain: _____

Do you brush twice a day? Y N Do you floss daily? Y N Do you use mouthwash? Y N Other _____

Do you have any of the following? Bleeding gums Y N Food caught in your teeth Y N Sensitive teeth Y N Loose teeth Y N

How would you rate your previous dental experience? 1 Being relaxed 5 Extremely nervous _____

Are you happy with the appearance of your teeth? Y N If no, what would you change? _____

Previous dentist: _____ Last visit date: ____/____/____ Reasons: _____

Medical History

Physician's name: _____ Address: _____ Phone #: (____) _____ - _____

Specialist's name: _____ Address: _____ Phone #: (____) _____ - _____

Specialist's name: _____ Address: _____ Phone #: (____) _____ - _____

Have you been under medical care within the past two years? Y N Reason: _____

When was your last physical exam? _____ Result: _____

When was your last visit to a physician? _____ Reason: _____

Medical History Cont.

Do you or have you ever experienced the following? Please indicate Y - yes N - no or (?) if not sure for each condition

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Head/neck injuries | <input type="checkbox"/> Alcohol / drug abuse | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> High / low blood pressure |
| <input type="checkbox"/> Abnormal bruising | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Congenital heart defect |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Glaucoma/Cataract | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Lung problem | <input type="checkbox"/> Heart surgery |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Heart attack/Angina |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Lupus | <input type="checkbox"/> Immune problems | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Swollen ankles, feet, or hands |
| <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Organ transplant | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Colitis/Ulcers | <input type="checkbox"/> Psychological problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Ever hospitalized | <input type="checkbox"/> Malignant hyperthermia | <input type="checkbox"/> Stroke | <input type="checkbox"/> Artificial valves |
| <input type="checkbox"/> Pre-medication with antibiotics for dental treatment | | | BP: _____ | HR: _____ |

Others _____

Please explain: _____

Women only: Are you taking birth control pills? ___Y ___N Are you pregnant? ___Y ___N Number of months? _____


Are you taking any prescription / over the counter drugs or herbal supplements? ___Y ___N Please list them: _____

Please list them: _____

Please circle your allergy (ies): Aspirin Barbiturates Codeine Anaesthesia Erythromycin Penicillin Clindamycin
 Sulfa drugs Tetracycline Injections Jewelry/metals Latex Others _____

Consent and Policies

- I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform the office of any changes in my medical status.
- I acknowledge that my dental benefits are my responsibility. I understand that I am responsible for payment of services rendered for my dependents and myself. Payment is due on the day of service rendered unless otherwise financially arranged. A fee of \$45.00 is charged per NSF cheque.
- My appointments are considered confirmed when scheduled. Cedarbrae Dental requires a notice of 2 business days for any changes to my reserved appointment. A fee of \$50.00 per appointment is charged for no-show, or short noticed cancellation.
- I have reviewed the information that explains how Cedarbrae Dental will use my personal information, and the steps Cedarbrae Dental will take to protect my information. I agree that Cedarbrae Dental can collect, use and disclose personal information about my dependents & myself as set out in the information about the office privacy policies. I can ask to see these policies at any time.
- I give consent to the dental staff to provide the necessary diagnosis and treatment, and authorize the release of my information and my dependents' information to my dental insurance company/plan administrator for Electronic Dental Insurance (EDI) submission.

We are pleased to answer any questions you may have or receive your feedback. Thank you for joining our dental family at  CEDARBRAE DENTAL

Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____