3561 Lawrence Ave. E, Unit 2, Scarborough ON MIH 1B2

# 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. Ms. Mrs. Miss. Dr.
Last name: _____First name: ____ Preferred name: _____Preferred pronoun:_____
Birthday: _____ Maritual status: Email: _____
Home address:_____City:_____ Province: _____Postal code:_____
Home phone #: ( ) - Work phone #: ( ) - ext: Other #: ( ) -
When is the best times to reach you?_____Preferred method of contact: 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: _____

Patient is a child Y N An adult under guardianship Y N Who is with the patient today?_____Relation:_____
Mother's name: _____Work #: ( ) -
Father's name: _____Work #: ( ) -
Legal guardian: _____Work #: ( ) -

Do you have dental insurance? Y N 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?
Are you happy with the appearance of your teeth? Y N If no, what would you change?
Previous dentist: _____Last visit date: _____Reason: _____

## 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

| | | | | |
|---|---|---|---|---|
| _____Abnormal bleeding | _____Head/neck injuries | _____Alcohol / drug abuse | ____Tuberculosis (TB) | _____High / low blood pressure |
| _____Abnormal bruising | _____Headaches/migraines | _____Steroid therapy | ____Persistent cough | _____ High cholesterol |
| _____Blood transfusion | _____Sinus problems | _____Cancer | ____Emphysema | _____ Congenital heart defect |
| _____Blood disorder | _____Glaucoma/Cataract | _____Radiation treatment | ____Asthma | _____ Heart murmur |
| _____Hemophilia | _____Artificial joints | _____Chemotherapy | ____Lung problem | _____Heart surgery |
| _____Liver disease | _____Seizures/Epilepsy | _____Venereal disease | _____Shortness of breath | _____Heart attack/Angina |
| _____Jaundice | _____Arthritis/Rheumatism | _____Herpes | _____Sleep apnea | _____Pacemaker |
| _____Hepatitis A B C | _____Lupus | _____Immune problems | _____Thyroid problems | _____Swollen ankles, feet, or hands |
| _____Sickle cell anemia | _____Organ transplant | _____HIV/ AIDS | _____Kidney problems | ____Rheumatic fever |
| _____Anemia | _____Colitis/UIcers | _____Mental health issues | _____Diabetes | _____Mitral valve prolapse |
| _____Prostate problems | _____Ever hospitalized | _____Malignant hyperthermia | ___Stroke | _____Artificial valves |

_____Pre-medication with antibiotics for dental treatment **BP:**_____**HR:**_____

Others _____

Please explain: _____

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 check 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.

Please initial

- 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: