Windwood Dental

PERSONAL INFORMATION

Surname _____ First _____ Date of Birth _____ (dd/mm/yy) Gender: M ❑ F ❑

Address _____ City _____ Postal Code _____

Occupation _____ Employer _____ Address _____

Phone (Res) _____ Phone (Cell) _____ Email _____

Preferred method of communication: ❑ Phone ❑ Email ❑ Text

Family Physician _____ Phone (Bus) _____

Date of Last Exam _____ (MM/DD/YYYY)

Health Card # _____

Name of Spouse, Parent, or Guardian _____

Driver's License # _____

Emergency Contact: _____ Phone #: _____

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

This information is collected to verify and settle any account balances not covered by insurance.

INSURANCE INFORMATION

PRIMARY

Policy Holder: _____

Date of Birth: _____

Employer: _____

Benefit Carrier: _____ (insurance co.)

Policy #: _____ (plan)

Certificate #: _____ (member ID)

Signature: _____

SECONDARY

Policy Holder: _____

Date of Birth: _____

Employer: _____

Benefit Carrier: _____

Policy #: _____

Certificate #: _____

Signature: _____

HEALTH INFORMATION

Have you ever had or have been treated for any of the following? Please check those that apply:

- ❑ AIDS/HIV
- ❑ Allergies
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy/Convulsions
- ❑ Emphysema
- ❑ Excessive Bleeding
- ❑ Fainting Seizures
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Heart Murmur F/O
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Latex Allergy
- ❑ Liver Disease
- ❑ Leukemia
- ❑ Mental Disorders
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorder
- ❑ Pacemaker
- ❑ Pregnancy

  Due _____
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Tumors
- ❑ Thyroid Problem
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Codeine Allergy
- ❑ Penicillin Allergy

Other:

- ❑ Complications after dental treatment
- ❑ Need for admission to a Hospital/Emergency
- ❑ Under the care of a physician
- ❑ Any health concerns

_____

_____

_____

DENTAL INFORMATION

Have you ever had or are you currently experiencing any of the following? please check those that apply:

❑ Bad Breath	❑ Dry Mouth	❑ Lip/Cheek Biting	❑ Root Canal Therapy
❑ Bad Experience	❑ Extractions	❑ Local Anaesthetic Reaction	❑ Strong Gag Reflex
❑ Bleeding Gums	❑ Fillings	❑ Loose/Broken Teeth	❑ Sensitivity to Cold
❑ Blisters in Mouth	❑ Fingernail Biting	❑ Mouth Breathing	❑ Sensitivity to Hot
❑ Burning Sensation	❑ Food trap in Teeth	❑ Mouth Pain	❑ Sensitivity to Sweets
❑ Chew on one Side	❑ Foreign Objects	❑ Orthodontic Treatment	❑ Sensitivity to Biting
❑ Cigarette Smoking	❑ Grinding Teeth	❑ Pain around Ear	❑ Sores/Growths in Mouth
❑ Clicking Jaw	❑ Gums Swollen/Bleeding	❑ Periodontal Treatment	❑ Syncope (Fainting)
❑ Crowns/Bridges	❑ Jaw Pain	❑ Removable Denture	❑ Any other conditions

Reason for todays visit: _____ _____

Former Dentist: _____ City: _____ Prov: _____ _____

Date of last dental visit: _____ Date of last dental x-rays _____ _____

How often do you brush: _____ Floss: _____ _____

Tell us what you liked about your last dental office: _____

Is there anything you did not like about your last dental office? _____

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

Do you have trouble sleeping? _____

Have you ever had an injury to your face, head or jaw? _____

Have you ever been advised to take antibiotics before dental treatment? _____

Are you nervous during dental treatment? _____

Do you smoke/chew tobacco? _____

MEDICATIONS

List of medications you are currently taking:

_____ _____ Pharmacy name: _____

_____ _____ City/Prov: _____

_____ _____ Phone: _____

I, _____, understand that the information contained in my dental history is important to my treatment. I certify that the above information is complete to the best of my knowledge and I have not knowingly omitted and pertinent information. I consent to the release of my medical information from my medical doctor/any health care provider as it is required by Windwood Dental. I authorize Windwood Dental to perform any diagnostic procedures as may be required to determine necessary treatment. **I assume all responsibility for fees associated with my dental treatment provided at each appointment for myself and all my dependents. I authorize electronic submission of benefit claims on my behalf to my insurance carrier**. I understand that any **missed appointment or cancellations** with less than 24 hours notice will be **billed $50.00.**

Signature:_____ Date:_____ Dentist's Signature:_____

Patient/Parent or Guardian