WELCOME TO OUR OFFICE

Goldstein
Vinegar

In order to render optimum health care service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. Therefore **PLEASE ANSWER EVERY QUESTION.**

PERSONAL INFORMATION

Date________________

Name______________________________________**Date of Birth**________**Age**____
Address____________________________________**Home phone**_______________
City______________________**Office phone**_______________**Cell** _______________
Postal Code________________ **Sex**____**Marital Status**_________
Occupation__________________**e-mail address**_____________________________
Name of person responsible for this account_________________________________
Do you have dental insurance?Yes____**No**____
Name of Policy Holder____
Employer's Name____
Insurance Company____
Group#______________________**Suffix/Division#**___________________________
Certificate or Subscriber ID#____
Whom may we thank for referring you?____________________________________

MEDICAL HISTORY

Physician's Name __________________________**Tele. No.**____________________
Have you been under the care of a doctor or clinic within the last 6 months for any treatment or observation? **Yes** **No**
Are you now taking or receiving any drugs or medications? **Yes** **No**
If so, name drug(s) and dosages____
____
Have you ever had or been treated for (please circle):

rheumatic fever	**heart murmur**	**heart trouble**	**stroke**
abnormal blood pressure	**jaundice**	**hepatitis**	**liver disease**
kidney disease/infection	**diabetes**	**psychiatric/mental disorders**	
epilepsy	**cancer**	**ulcers**	**A.I.D.S or HIV positive**

Do you have or have you ever had an operation or any other serious illness other than the above? **Yes** **No**
If yes, explain____
Have you ever had asthma, hay fever or hives? **Yes** **No**
Are you allergic to anything? Please list______________________________
____
Have you ever had an adverse reaction to a local anaesthetic? **Yes** **No**
Have you ever been warned against taking any medicine or drug? Yes **No**
Do you have any abnormal bleeding problems or blood disorders? Yes **No**

Women only: Are you pregnant? Yes No

Primary reason for this appointment:
____ Examination
____ Emergency
____ Consultation

DENTAL HISTORY

Do you have a specific dental problem? Yes No
Describe ____________________

Do you have dental examinations on a routine basis? Yes No
Last visit ____________________

Would you describe your present dental health as good? Yes No
Comments ____________________

Do you feel nervous about having dental treatment? Yes No

Have you ever had a bad experience in a dental office? Yes No
Describe ____________________

Are you happy with your smile? Yes No

If "No": What would you like to change? (Please circle)
Colour Straightness Replace missing teeth
Replace dark or discoloured fillings

Do you ever clench or grind your teeth? Yes No

Do you ever have clicking, popping or discomfort in the jaw joints? Yes No
Describe ____________________

Has any member of your family ever been treated in this office? Yes No

METHOD OF PAYMENT

If Responsible Party does not currently have an account with this office, Please check one of the following:

____ Payment in full at each appointment
____ Financial arrangements for Non-Insured Expenses (Upon approval)
____ Visa ____ Mastercard ____ Debit

Authorization

I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical and dental histories are correct to the best of my knowledge. I understand that my dental insurance (if insured) is a contract between the insurance carrier and me, and not between the insurance carrier and the dentist, and that I am still responsible for all dental fees. I understand that I will be charged for all dental treatment, and that any payments received by the Dental Office from my insurance company will be credited to my account, or refunded to me if I have paid the dental fees incurred.

Patients Signature Date

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