Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

What are your expectations from our office if any_____

List any medications and dosage (including Herbal):

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Have you ever had any of the following? Please check (and circle where more) those that apply:

Neural
- ☐ Seizures/Epilepsy
- ☐ Fainting/Black Out
- ☐ Dizziness
- ☐ Nervous/Mental Disorders
- ☐ Stroke
- ☐Depression

Pulmonary
- ☐ Asthma / COPD
- ☐ Difficulty breathing
- ☐ Respiratory problems
- ☐ Tuberculosis

Cardiovascular
- ☐ Angina
- ☐ Heart Attack
- ☐ Bleeding Disorder
- ☐ High/low Blood Pressure
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Rheumatic fever
- ☐ Heart Murmur

Digestive
- ☐ Acid reflux Disease
- ☐ Stomach Problems
- ☐ Ulcers

Neoplastic
- ☐ Cancer
- ☐ Growths/Tumors
- ☐ Radiation/Chemo year _____

Immune
- ☐ Hay fever
- ☐Allergy

Inflammatory
- ☐ Arthritis
- ☐ Rheumatism
- ☐ Osteoporosis

Infectious
- ☐ AIDS/ HIV
- ☐ Hepatitis A B C
- ☐ Venereal Disease

Other
- ☐ Diabetes
- ☐ Artificial Joints
- ☐ Glaucoma
- ☐ Sinus Problems
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Sleep Apnea
- ☐ Organ Transplant
- ☐ Thyroid problems

Surgeries 1. _____year_____ 2._____year_____

3._____year_____ 4._____year_____

Notes:_____

- Have you ever had any complications following dental treatment? ☐ Yes ☐No

  If yes, please explain: _____

- Have you been admitted to a hospital or needed emergency care during the past 2 years? ☐Yes ☐ No

- For women only: Are you breastfeeding or is it possible that you are pregnant? ☐Yes ☐ No

  Due date_____

- Are you now under the care of any physician (under any kind of treatment)? ☐ Yes ☐ No

  If yes, please explain: _____

- Do you have any health problems that need further clarification? ☐ Yes ☐No

  If yes, please explain: _____

- Do you smoke? ☐ Yes ☐ No How many cigarettes a day? _____

  - If you used to smoke, when did you quit? _____

- Do you use recreational drugs? ☐Yes ☐ No If so, please list which kind _____

- Do you have to take antibiotics every time prior to dental work or surgery? ☐Yes ☐ No

- Do you take any medication that thins your blood or affects clotting/bruising? ☐ Yes ☐No

- Have you or anyone related to you ever had problems with anesthetic? ☐ Yes ☐ No

  If yes please explain._____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____

Signature of patient, parent or guardian

In case of emergency we should notify: Name _____

Relationship_____ Phone _____

Referral Information

Whom may we thank for referring you to our practice?

☐ Dental office ☐ Internet ☐ Flyer _____

☐ Yellow Pages ☐ School ☐ Other _____

☐ Walk-by location ☐ Sign ☐ Name of person referring you _____

Consent for Services/ Office Agreement

*I understand that my family's appointments are valuable, and that **2 Business days** must be given if we are unable to attend appointments. A missed standard appointment may incur a fee.
*I will be required to **pay for my family treatment at each visit**. For treatment involving laboratory work, I will be required to place a deposit for the estimated lab work required (this is separate from Dental office fees).
*I understand that outstanding account balances will be passed to a Credit Agency and/or to the Ontario Court System.
*I understand there are premium times in great demand. If I am not attending these premium appointments and thus preventing other patients from making effective use of these times, I will be required to make use of regular hours for treatment.
***My dental insurance plan is a contract between myself and the organization providing me with the coverage**. It is my responsibility to ensure that the treatment I request is covered. However, Lancaster Dental will help me to the best of their abilities to ensure accurate and timely completion of my insurance forms. Lancaster Dental has **NO** knowledge of what is covered by my insurance plan. If I have a booklet, Lancaster Dental will be able to interpret it for me. Many plans require Pre-Determinations to be forwarded for more extensive treatment. Lancaster Dental will complete these for me. To avoid any delays in receiving my payment from my insurance company I must send my claim immediately, if it is not submitted electronically.
* Lancaster Dental also understands that your time is valuable so we are intent on starting your appointment on time. With the possible exception of short notice emergencies (which all of us might get and we would like to be seen as soon as possible) we will not double book appointments.
* Lancaster Dental will always make every attempt to see emergency cases promptly.
* Lancaster Dental will accept Visa, MasterCard, debit, cash or cheque.
* Lancaster Dental will propose my dental treatment with my long-term dental health in mind, and will do their best to give an accurate estimate.

Consent for Collection, Use and Disclosure of Personal Information

* I agree that Lancaster Dental has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I can request to see a copy of the consent form and agree the personal information may be collected, used and disclosed as set out in the Privacy Policy of the Office which is in accordance with the Personal Health Information Protection Act, 2004.

I have read the above conditions of treatment, payment and personal information and agree to their content.

_____ Date: _____

Signature of patient, parent or guardian

Patient Information

• Patient Name_____ Date_____
Last First MI Preferred Name

Gender ☐F ☐M **How would you rate your smile? From 1-10____**

Birth Date_____Email_____
Day Month Year

Address_____
Street Apartment #

_____ _____
City Province Postal Code

Phone (Home) _____ (Cell) _____

(Work) _____ (Ext)_____
Preferred contact number: ☐ Home ☐ Cell ☐ Work ☐ Email

Preferred appointment times Morning Afternoon Evening Any Time M T W T F

• **Allergies** _____

• Family Doctor_____ • Health Card _____

• Employment Information

Employer Name_____ Occupation _____

Responsible Party Information
Insurance Information

Responsible for payment ☐self or ☐other _____
NAME & Relation with patient (parent or guardian)

Primary

Name of Insured _____ Is the insured our patient? ☐ Yes ☐No
Last First

Insured's Birth Date _____ Group/Policy # _____ ID #_____

Insurance Plan Company Name: _____

Patient's relationship to insured: Self Spouse Child Dependant Common Law

Secondary

Name of Insured_____ Is the insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ Group/Policy #_____ ID #_____

Insurance Plan Company Name: _____

Patient's relationship to insured: Self Spouse Child Dependant Common Law