GALT DENTAL CARE

WELCOME TO OUR DENTAL OFFICE
PATIENT INFORMATION

Date:_____ HEALTH CARD #_____ Date of Birth _____ /_____ /_____
(Day) (Month) (Year)

Your co-operation in completing this questionnaire is essential to providing you with highest standard of dental care. Please answer the questions as accurately as you can. If you have any questions or doubts please ask the treating dentist or our receptionist, who is available to assist you with completion of this form. All information is **strictly confidential** and will remain with the office.

PLEASE PRINT

NAME: **As it appears on your insurance card.**

_____
(Last) (First) (Initial) (Title)

ADDRESS_____
(Street) (City) (Prov.) (Postal Code)

HOME PHONE _____ BUS. _____ EXT _____ CELL _____

EMAIL ADDRESS _____

FAMILY PHYSICIAN _____ PHONE _____ FORMER DENTIST _____

HOW DID YOU HEAR ABOUT US?

FRIENDS/FAMILY _____ WHOM MAY WE THANK? _____

□ OUR WEBSITE □ GOOGLE □ NEWSPAPER □ SIGN BOARD □ OTHERS

CONTACT NAME IN CASE OF EMERGENCY:

NAME _____ TELEPHONE _____ RELATIONSHIP _____

INSURANCE INFORMATION

Name of Policy Holder	Date of Birth	Relationship to Policy Holder	Insurance Company
Name of Employer	Group/Policy #	Certificate/ID #	Insurance Co. Phone #

IS THERE SECONDARY INSURANCE?

Name of Policy Holder	Date of Birth	Relationship to Policy Holder	Insurance Company
Name of Employer	Group/Policy #	Certificate/ID #	Insurance Co. Phone #

SIGNATURE ON FILE AUTHORIZATION

By signing this statement you are authorizing Galt Dental Care to complete any necessary insurance claim forms on your behalf. You are hereby also authorizing the release of any medical or other information which may be needed in order to process your dental claims with your specific insurance company. Your signature will be kept on file and shall be referred to when insurance claim forms are submitted for any dental services you have received.
Note: Patients that are incapable of signing, or are under the age of 18, must obtain the signature of a parent or legal guardian in the patient's place.

NAME OF PATIENT _____ SIGNATURE _____

PRINT NAME _____

NAME OF LEGAL GUARDIAN OR PARENT (if applicable) _____ DATE _____

PAYMENT AUTHORIZATION

I hereby authorize the release of information contained in claims to be submitted electronically or manually to my insuring company plans administrator(s) and authorize direct payment to Dental Office for benefits received. I am solely responsible for any portion not paid by my insurance company and I will pay for it.

SIGNATURE _____ DATE _____

CONFIDENTIAL MEDICAL HISTORY

1. When was your last physical examination with your family doctor? D_____ M _____Y _____
2. Are you presently under the care of your family physician □ Y □ N

   Please Specify _____
3. Have you ever been hospitalized and was surgery performed □ Y □ N

Please specify _____
4. Have you recently or are presently taking any prescription or non-prescription drugs, including vitamins?

   1. _____2. _____3. _____ 4. _____

   5. _____ 6. _____
5. Have you any allergies to any drugs or medications □ Y □ N

   i.e. Penicillin, Sulfa. Please specify _____
6. Have you any environmental allergies? i.e. Hay fever _____
7. Do you have a heart murmur or mitral valve prolapse? □ Y □ N
8. Do you have artificial joints or valves? □ Y □ N Date of surgery D_____ M_____ Y _____
9. Do you experience shortness of breath or chest pain? □ Y □ N
10. Do you bleed excessively from a cut or injury, or bruise easily? □ Y □ N
11. Do your ankles, feet or hands swell? □ Y □ N
12. Have you lost or gained weight recently? □ Y □ N
13. Are you dependent on tobacco/alcohol or drugs? □ Y □ N Please Specify _____
14. Do you have or have you had (Please check)?

□ A.I.D.S./HIV	□ Fainting or dizzy spells	□ Anemia	□ Heart diseases or attack
□ Rheumatic/Scarlet fever	□ Arthritis/Rheumatism	□ Hepatitis A, B, C	□ Sinus trouble
□ Bronchitis/Asthma	□ Herpes/Cold sores	□ Stomach/Intestine problems	□ Cancer
□ High/low blood pressure	□ Stroke	□ Chemotherapy/Radiation	□ Kidney disease
□ Thyroid disease	□ Cortisone/steroid	□ Liver disease	□ Tuberculosis
□ Diabetes	□ Lung disease	□ Venereal disease	□ Epilepsy or seizures
□ Mental/Nervous disorders	□ Mitral valve prolapse	□ Other _____	

15. Is there anything else you think you should tell me about your health? Please specify
    _____
16. Are you, or is it possible you may be pregnant? □ Y □ N

CONFIDENTIAL DENTAL HISTORY

1. Are you having any discomfort at this time? □ Y □ N

   Please specify_____
2. When was your last dental visit?
3. Do your gums feel tender or swollen? □ Y □ N
4. Have you ever had any complication with local (freezing) or general anesthetic? □ Y □ N

   Please specify_____
5. Are you aware of any lump or swelling in your mouth? □ Y □ N
6. Are you satisfied with the appearance of your teeth? □ Y □ N

   If NO, please specify _____
7. Are you anxious about dental treatments? □ Y □ N
8. Describe any concerns you may have with your teeth _____
   _____
9. Do you currently experience

□ loose teeth	□ bleeding gums	□ sore gums	□ sensitive teeth
□ bad breath	□ earache	□ neck pain	□ headache
□ gagging	□ unexplained nose bleeds	□ missing teeth	□ spaced or crooked teeth
□ unsatisfactory dentures	□ popping or clicking in the jaw joints		

Our professional services are rendered to you, not your insurance company. Therefore, you are directly responsible to us for the obligation of treatment in full. You will then be variably re- imbrused by your insurance company, unless an alternative financial agreement has been arranged.

This is to certify that I, the undersigned have provided an accurate and complete personal and medical/dental history and consent to the preforming of the dental procedures agreed to be necessary.

PATIENT'S/PARENT'S/LEGAL GUARDIAN SIGNATURE _____

PRINT NAME_____ DATE _____