YONGE ELLINGTON DENTAL

## CONTACT INFORMATION

First Name_____ Last Name_____
Date of Birth: ___ /____ /_____ Address: _____
City/Province: _____ Postal Code _____- _____
Home: _____ Work _____ ext ( _____)
Cell _____ Email: _____
Do you prefer Email confirmation for appointments? **YES NO**
Person responsible for account if different from above (Guardian/Parent) Name:_____
Contact Number: _____

**Do you have dental insurance coverage? Please circle: Yes No**
**Primary Insurance**
**Subscriber Name :_____ Date of Birth:___/ ___ /_____**
**Employer:_____**
**Insurance provider_____**
**Group/Policy#_____Certificate/ID#_____Div#_____**
**Secondary Insurance**
**Subscriber Name :_____ Date of Birth:___ /___ /_____**
**Employer:_____**
**Insurance provider_____**
**Group/Policy#_____Certificate/ID#_____Div#_____**

1. How did you hear about us? _____
2. Do you have a special reason for your visit?_____
3. What, if anything in the past has kept you from having dental treatment?_____
4. Can you eat anything you want, whenever you want? _____
5. It's valuable for me to know how you feel about your smile, could you tell me?
   _____
6. What has dentistry been like for you? _____
7. What do you look for most in a dental office? _____

## DENTAL HISTORY

Do your gums bleed when you brush **YES NO**
Do you ever experience a bad taste/smell in your mouth? **YES NO**
Are your gums shrinking or your teeth getting longer? **YES NO**
Are any of your teeth sensitive to heat or cold? **YES NO**
Are any of your teeth sore to chew on? **YES NO**
Does your jaw ever "click" or "crack"? **YES NO**
Have you ever had a jaw or mouth injury? **YES NO**
Do you clench or grind your teeth? **YES NO**
When was your last dental treatment?_____What was done at that time? _____
Did you have x-rays taken at the last appointment? **YES NO**
**If not, when was the last time you had x-rays taken? _____**
What was the frequency of your cleaning appointments _____ **MONTHS**
How many times per day do you; **BRUSH** _____ **FLOSS** _____

Patient's Initials _____

## MEDICAL HISTORY

**Medical Alert YES NO**
Your answers will help The Doctor/Hygienist to determine a proper and safe treatment for you. The information is confidential and will be kept in your dental chart. On subsequent visits, any change in your health should be reported.
**Physician's Name: _____ Tel: _____**
**Emergency Contact:_____Tel:_____**
Are you in good health? **YES NO**
Are you currently under the care of a Physician? **YES NO**

**MEDICATIONS:**
**Name of Medication**:_____ **Dosage**:_____**Frequency**:_____
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Any recent changes in the dosage of your medication? **YES NO**_____
When was your last **medical** exam? _____
Do you have any allergies? **YES NO** If so, what?_____
Have you ever had a bad reaction to local anesthetic (freezing) **YES NO** If so, describe:_____
Has your physician ever told you to take antibiotics before dental treatment? **YES NO** If so, why?_____
Have you ever experienced complications following a medical or dental procedure? **YES NO** If so describe,_____
Have you ever been hospitalized? **YES NO** If so when and why?_____
Have you had joint replacement? **YES NO** if so, when? _____
Do you smoke? **YES NO** If so, for how long _____ How much _____
Have you ever had a problem with drug or alcohol dependency? **YES NO**
*FOR WOMEN ONLY*, Are you taking birth control pills? **YES NO** Are you pregnant?**YES NO UNAWARE**

**DO YOU KNOW OR HAVE YOU EVER HAD THE FOLLOWING?**
Heart murmur, pacemaker, bleeding problems, mitral valve prolapse or any know heart condition? **YES NO**
Have you been diagnosed with high blood pressure? **YES NO**
Have you had Hepatitis A, B or C? **YES NO**
Have you ever had Rheumatic Fever? **YES NO**
Are you diabetic? **YES NO**
HIV? **YES NO**
Is there anything we have not mentioned that you think we should know regarding your medical history?
**YES NO** If so, what?_____

I certify that I have read understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. If required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required achieving a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided.

I agree that Dr Tina Ghaboulian has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of consent form and agree that personal information may be collected and used and disclosed as set out in the privacy policy at this dental office and am in accordance with the Personal Health Information Protection Act, 2004.

Signature _____ Date _____
(Patient OR parent/guardian)

Signature_____ Date _____
(Dentist)