

**Welcome to Glenashton Dental Centre - Confidential Patient Information**

Patient Details - Last name:

First name:

Middle name:

Today's Date:

Birth Date:

Gender:

☐ Male ☐ Female

Status:

☐ Married ☐ Single ☐ Child ☐ Other

Name of Spouse:

Names of Children:

Phone (Home):

Phone (Work):

Ext:

Best time to call:

Mobile:

Email:

Preferred appointment times:

☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Address - Street:

Apartment #:

City/Town:

Province:

Postal Code:

**Health Information**

Name of Previous Dentist:

Dentist Telephone Number:

Date of Last Dental Visit:

Reason for this visit:

**Have you ever had any of the following? Please check those that apply:**

- |  |   |
|--|---|
| <input type="checkbox"/> AIDS / HIV                      | <input type="checkbox"/> Glaucoma                 |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Glandular disorder       |
| <input type="checkbox"/> Angina Pectoris                 | <input type="checkbox"/> Growths                  |
| <input type="checkbox"/> Anorexia Nervosa                | <input type="checkbox"/> Head/neck Injuries       |
| <input type="checkbox"/> Artificial Heart valve          | <input type="checkbox"/> Heart Disease/attack     |
| <input type="checkbox"/> Arthritis/Rheumatism            | <input type="checkbox"/> Heart Murmur             |
| <input type="checkbox"/> Artificial Joints (hips, knees) | <input type="checkbox"/> Heart Rhythm Disorder    |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Mitral Valve Prolapse    |
| <input type="checkbox"/> Blood Disease                   | <input type="checkbox"/> Migraine Headaches       |
| <input type="checkbox"/> Bronchitis                      | <input type="checkbox"/> Hepatitis A/B/C          |
| <input type="checkbox"/> Bulimia                         | <input type="checkbox"/> Herpes                   |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> High/Low Blood Pressure  |
| <input type="checkbox"/> Circulation Problems            | <input type="checkbox"/> Hodgkin's disease        |
| <input type="checkbox"/> Congenital Heart Lesions        | <input type="checkbox"/> Hyper/hypo Glycemia      |
| <input type="checkbox"/> Cortisone/steroid               | <input type="checkbox"/> Jaundice                 |
| <input type="checkbox"/> Chemotherapy/Radiation          | <input type="checkbox"/> Kidney Disease           |
| <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Liver Disease            |
| <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Leukemia                 |
| <input type="checkbox"/> Drug/alcohol dependency         | <input type="checkbox"/> Lung disease             |
| <input type="checkbox"/> Emphysema                       | <input type="checkbox"/> Malignant hyperthermia   |
| <input type="checkbox"/> Epilepsy                        | <input type="checkbox"/> Mental/nervous disorders |
| <input type="checkbox"/> Excessive Bleeding              | <input type="checkbox"/> Organ transplant/implant |
| <input type="checkbox"/> Fainting                        | <input type="checkbox"/> Psychiatric disorder     |

- |  |
|--|
| <input type="checkbox"/> Pacemaker               |
| <input type="checkbox"/> Recreational Drug use   |
| <input type="checkbox"/> Respiratory Problems    |
| <input type="checkbox"/> Rheumatic Scarlet fever |
| <input type="checkbox"/> Sickie Cell Disease     |
| <input type="checkbox"/> Sinus Problems          |
| <input type="checkbox"/> Stomach Problems        |
| <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Thyroid Condition       |
| <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Ulcers/Tumors           |
| <input type="checkbox"/> Venereal Disease        |
| <input type="checkbox"/> Sleep Apnea             |

**FOR WOMEN ONLY:**Are you breast feeding ☐ Yes ☐ NoAre you pregnant: ☐ Yes ☐ No

Due Date:

**Adverse effects to any of the following:**

- |  |
|--|
| <input type="checkbox"/> Penicillin        |
| <input type="checkbox"/> Sulfonamide       |
| <input type="checkbox"/> Aspirin           |
| <input type="checkbox"/> Barbiturates      |
| <input type="checkbox"/> Codeine           |
| <input type="checkbox"/> Darvon            |
| <input type="checkbox"/> Local Anaesthetic |
| <input type="checkbox"/> None              |
| <input type="checkbox"/> Other             |

Allergies (hay fever, latex etc.)

Please list your Medications:

Family history of adverse anesthetic outcomes ☐ No ☐ Yes  
 Do you have bad breath or a bad taste in your mouth? ☐ No ☐ Yes  
 Do your jaws crack, pop, or grate when you open widely? ☐ No ☐ Yes  
 Are you satisfied with your teeth? ☐ No ☐ Yes

If not, Specify \_\_\_\_\_

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

If yes, please explain: \_\_\_\_\_

Have been to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes,

If yes, please explain: \_\_\_\_\_

Are you now under the care of a physician? ☐ No ☐ Yes

If yes, Please explain: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any health problems that need further clarification? \_\_\_\_\_

Do you smoke? How much per day? \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, \_\_\_\_\_

☐ Medical Walk in ☐ Yellow Pages ☐ Newsletter ☐ Road Sign ☐ Newspaper ☐ Pharmacy ☐ Other: \_\_\_\_\_

### Special Concerns:

Are you nervous about dental treatment? ☐ No ☐ Yes \_\_\_\_\_

Would you like more information on tooth whitening? ☐ No ☐ Yes \_\_\_\_\_

Would you like more information on braces? ☐ No ☐ Yes \_\_\_\_\_

Are you aware of night time tooth grinding? ☐ No ☐ Yes \_\_\_\_\_

Do you require a sports mouth guard? ☐ No ☐ Yes \_\_\_\_\_

## Insurance Holder's Information

### Primary Insurance Plans

Name of Insured: \_\_\_\_\_

Is Insured a patient? ☐ No ☐ Yes

Insured's Birth Date: \_\_\_\_\_

ID/Cert #: \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance Plan Provider: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:

☐ Self ☐ Spouse ☐ Child

☐ Other \_\_\_\_\_

### Secondary Insurance Plans

Name of Insured: \_\_\_\_\_

Is Insured a patient? ☐ No ☐ Yes

Insured's Birth Date: \_\_\_\_\_

ID/Cert #: \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance Plan Provider: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:

☐ Self ☐ Spouse ☐ Child

☐ Other \_\_\_\_\_

**Financial Policies**

Your insurance benefits are between you, your employer and your insurance company. Any benefit difference (deductible, fee guide, ineligible service or co-payment) is your responsibility.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

All estimates for approximate.

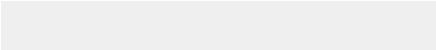
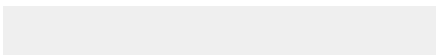
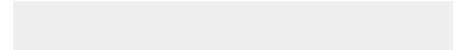
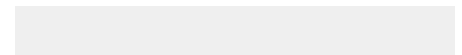
**Privacy act:**

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. I understand that Glenashton Dental Office has a privacy act & will take the steps to protect my information. I know that your office has a Privacy Code, and I can ask to see the code at any time. I agree that Dr.Harbans Singh Bamrah/ Glenashton Dental Centre can collect use and disclose personal information about myself as set out in the privacy act. I hereby assign my benefits, payable from claims submitted electronically to Dr. Harbans S. Bamrah and authorize payment directly to him/her. This authorization shall continue in effect until the undersigned revokes the same.

**General Release**

I, the undersigned, certify that all of the information I have completed is correct and that I have not knowingly omitted data. I understand that the information contained in the medical and dental history is important to my treatment and if I ever have any change in my health, I will inform the doctors at the next appointment without fail. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my treatment or dental diagnostic procedures. I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

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

**Signature of patient, parent, guardian, or guarantor of payments****Printed Name of patient, parent, guardian, or guarantor****Date****Dentist Signature**