DENTISTRY
IN THE VALLEY

815 O'Brien Road, Renfrew, Ontario, K7V 0B3
P: (613) 432-7542 E: info@valleydental.ca

PERSONAL INFORMATION

Patient's First Name: _____

Patient's Last Name: _____

Address: Street: _____ City: _____

Province: _____ Postal Code: _____

Tel: (_____) - _____-_____ Work: (_____) - _____-_____

Cell: (_____) - _____-_____ Would you like text reminders? _____

Email: _____

Date of Birth: Day: _____ Month: _____ Year: _____

Place of Birth: _____

Social Insurance Number: _____-_____- _____ **AND/OR**

Health Card Number: _____

EMPLOYMENT INFORMATION

Employer Name: _____

Occupation: _____

Address: _____

BENEFIT INFORMATION:

PRIMARY:

Name of Insured: _____

Insured's Date of Birth: Day: _____ Month: _____Year: _____

Insured's Address: Street: _____ City: _____

Province: _____ Postal Code: _____

Insured's Employer Name: _____

Insuring Agency (i.e.Sunlife): _____

Plan / Policy / Group #: _____

Certificate / I.D #: _____

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SECONDARY:

Name of Insured: _____

Insured's Date of Birth: Day: _____ Month: _____Year: _____

Insured's Address: Street: _____ City: _____

Province: _____ Postal Code: _____

Insured's Employer Name: _____

Insuring Agency: i.e. Sunlife: _____

Plan / Policy / Group #: _____

Certificate / I.D #: _____

REFERRAL INFORMATION:

Whom may we thank for your referral to Dentistry in the Valley:

Another Patient: _____ Relative: _____ Dental Office: _____Web Site: _____

Yellow/White Pages: _____ News Paper: _____ Drove By: _____

Name of person or office, referring you to our practice: _____

Payment is required upfront at the time of treatment for all dental services rendered. In consideration for the dental services rendered to me, I agree to pay using the payments methods available at this location. This office will help prepare any insurance forms however; there is limited information access due to the Privacy Act. I am responsible to know my dental insurance information and will access it from my benefit administrator.

_____

Signature of Patient

_____

Date

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IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:_____

RELATIONSHIP: _____

DAY-TIME PHONE: _____

NAME OF FAMILY DOCTOR: _____

PHONE OR ADDRESS: _____

(1) NAME OF MEDICAL SPECIALIST:_____

AREA OF SPECIALITY: _____

PHONE OR ADDRESS: _____

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. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? YES NO

_____

2. When was your last medical checkup?

_____

3. Has there been any change in your general health in the past year? If yes, please explain.
YES NO

_____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please explain.
YES NO

_____

5. Do you have any allergies? If you answered yes, please list using the categories below:
YES NO

a) medications
b) latex/rubber products
c) other e.g. hayfever, foods

_____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
YES NO

_____

7. Do you have or have you ever had asthma?
YES NO

8. Do you have or have you ever had any heart or blood pressure problems?
YES NO

_____

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9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
YES NO

10. Do you have a prosthetic or artificial joint?
YES NO

11. Have you ever been advised by your doctor to take antibiotics before dental treatment?
YES NO

12. Do you have any conditions or therapies that could affect your immune system?
e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
YES NO

13. Have you ever had hepatitis, jaundice or liver disease?
YES NO

14. Do you have a bleeding problem or bleeding disorder?
YES NO

15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. .
YES NO

16. Do you have or have you ever had any of the following? Please circle.

Chest pain, angina	shortness of breath	pacemaker	drug/alcohol dependency
Heart attack	prosthetic heart valve	lung disease	diet pill therapy
Stroke	tuberculosis	stomach ulcers	
Thyroid disease	kidney disease	arthritis	
Cancer	diabetes		

17. Are there any conditions or diseases not listed above that you have or have had? If so, what?
YES NO

18. Are there any diseases or medical problems that run in your family?
(e.g. diabetes, cancer or heart disease)
YES NO

19. Do you smoke or chew tobacco products? YES NO

20. Are you nervous during dental treatment?
YES NO

21. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?
YES NO

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: DATE:

DENTIST SIGNATURE: DATE: