MEDICAL AND CONTACT INFORMATION

PATIENT INFORMATION (Confidential)

Name ____________________ Birth date ____________________

Address ____________________ City ____________ Prov ________ Postal Code ________

Home Phone ____________________ Work Phone ____________________ Cell Phone ____________________

Employer ____________________ Marital Status ____________________

E-mail ____________________ Gender ____________________

Emergency Contact/Parent Contact ____________________ phone # ____________ Alt phone # ____________

How did you hear about us? ____________________

If you selected Family/Friend or other, whom Shall We Thank For Your Referral? ____________________

ACCOUNT INFORMATION

Who would you like your statement sent to?

Name ____________________ Address ____________________

Postal Code ____________________ Phone Number ____________________

DENTAL INSURANCE

☐ Yes ☐ No Insurance Company Name ____________________

Subscriber's Name ____________________ Subscriber's Date of Birth ____________________

Employer ____________________

Policy Number ____________________ Certificate Number ____________________

Do you have or have had any of the following? Please check all that apply.

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug/Alcohol Dependency
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Gastro-Intestinal Problems
- ☐ Head Injuries
- ☐ Heart Disease/Angina
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hip, Knee, or Joint
- ☐ Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Pregnant
- ☐ Osteoporosis Medications
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoker
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Tumors
- ☐ Ulcers/Colitis
- ☐ Venereal Disease

Aspen Springs DENTAL CENTRE

A LIFETIME OF SMILES

1 Hartwell Ave., Suite 300
Bowmanville, ON L1C 0N1
Phone: 905-623-3133
Email: info@aspenspringsdental.com
Website: AspenSpringsDental.ca

MEDICAL AND CONTACT INFORMATION

Any other medical conditions not mentioned?____

____

____

Comments____

____

____

What is your main concern with regards to your oral health (for example: Oral cancer, cavities, gum disease, missing or decaying teeth, bad breath, maintaining your oral health, etc.) ____

____

____

Is there anything about the appearance of your teeth that you would like changed?____

____

Name of your family physician_______________________________Phone #_______________

Date of last physical____

Are you taking any prescription or non-prescription drugs? ☐ Yes ☐ No

If yes please list____

____

Are you allergic to any of the following:

Codeine	☐ Yes ☐ No
Penicillin	☐ Yes ☐ No
Local Anesthetics (dental freezing)	☐ Yes ☐ No
Latex	☐ Yes ☐ No
Other	☐ Yes ☐ No

It is my responsibility to inform Aspen Springs Dental Centre of any changes in my medical status. I authorize the dental staff to perform any necessary dental services during diagnosis and treatment with my informed consent. I authorize the dental staff to perform any necessary dental services during dignosis and treatment with my informed consent. I authorize photographs and/or x-rays to be taken of me and placed in my file as part of my records. I agree that Aspen Springs Dental Centre can collect, use and disclose personal information about me as set out in Ontario's Personal Health Information Protection Act (PHIPA). I authorize the release, to my insurance company or plan administrator, of the information contained in claims submitted electronically.

Signature_______________________________________Date_________________________

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