THOROLD FAMILY DENTAL

In order to render optimum dental service, it is necessary to become acquainted with the vital information related to each patient. All information is strictly confidential and although some questions may seem unimportant at the moment, they may become vital in the case of an emergency.

PATIENT PERSONAL INFORMATION

Name: _____ Birth date: _____ Referred by: _____

Address: _____ City: _____ Postal Code: _____

Email: _____ Cell Phone: _____ Home Phone: _____

Preferred method of contact: email ☐ cell phone ☐ home phone ☐ Student: ☐ School: _____

Marital Status: _____ Employer: _____ Occupation: _____ Language Preferred: _____

Health Card # _____ Male ☐ Female ☐

MEDICAL Do you have or ever had?

☐ Hepatitis A ☐ B ☐ C ☐	☐ High Blood Pressure	☐ Jaundice	☐ Rheumatic Fever	☐ Diabetes
☐ Tuberculosis	☐ Lung Disease	☐ Cancer	☐ Thyroid Disease	☐ Kidney Disease
☐ Bacterial Endocarditis	☐ Heart Attack	☐ Heart Murmur	☐ Pacemaker	☐ Heart Surgery
☐ Angina	☐ Mitral Valve Prolapse	☐ Stroke	☐ Joint Replacement	☐ Epilepsy
☐ Stomach Ulcers	☐ HIV/Aids	☐ Sinusitis	☐ Arthritis	☐ Lupus
☐ Drug Dependency	☐ Alcohol Dependency			

1. Have you ever had a serious illness or are you currently under the care of a physician? Yes ☐ No ☐
   If so, please describe _____
2. Physician Name: _____ Phone: _____
3. Medical Specialist Name: _____ Phone: _____ Specialty _____
4. Have you had major surgery? If so, please describe:
   Procedure _____ Date _____
   Procedure _____ Date _____
5. List ANY medication, drugs, vitamins or pills you are presently taking:

   _____
6. Name of Pharmacy: _____ Phone: _____
7. Do you require Premedication before dental appointments? Yes ☐ No ☐
   If so, please describe reason _____
8. Do you have? Asthma ☐ Hay Fever ☐ Skin Rash ☐ Allergies ☐
9. Are you currently using? Tobacco Products ☐ Street Drugs ☐ Naturopathic/herbal products ☐
10. Have you ever experienced an unusual reaction to:
    i) Anaesthetic Freezing ☐ ii) Aspirin ☐
    iii) Sulfa based medication ☐ iv) Penicillin based medication ☐
    v) Sleeping Pills ☐ vi) Codeine ☐
11. Do you bruise easily or bleed abnormally? Yes ☐ No ☐
12. Do you have any blood disorders such as: anaemia or thin blood? Yes ☐ No ☐
13. Have you had (please circle) an injury, surgery, radiation treatment on your head, face, jaw? Yes ☐ No ☐
14. Do you have a prosthetic or artificial joint? If so, where _____ Yes ☐ No ☐
15. Are there any medical conditions or diseases not listed above that you have or had? Yes ☐ No ☐
    If so, please explain _____
16. Woman only, are you pregnant? Yes ____ No ____ If so, expected due date? _____

DENTAL

1. Do you have any dental concerns? _____
2. How frequently do you visit your dentist? ____ 3-6 months ____ annually ____ other
3. Have you ever had teeth extracted due to:
   ☐ An accident ☐ Decay ☐ Gum disease ☐ Orthodontics
4. Do you have or had?
   ☐ Fixed Bridge(s) ☐ Implants ☐ Partial Denture(s) ☐ Full Denture(s)
   ☐ Orthodontics ☐ Veneers ☐ Crowns ☐ Root Canal Treatment
   ☐ Periodontal Treatment ☐ Oral Piercings
5. Do you have any oral habits, such as?
   ☐ Clenching ☐ Grinding ☐ Nail Biting ☐ Other
6. How often do you brush your teeth? _____ Floss? _____

DENTAL INSURANCE

Do you have dental insurance ☐ Yes ☐ No

PRIMARY DENTAL PLAN

Subscriber Name: _____

Subscriber Date of Birth: _____

Relationship to patient: _____

Group/Policy # _____ Division # _____

ID/Certificate # _____

Insurance Company: _____

Employer Name: _____

SECONDARY DENTAL PLAN

Subscriber Name: _____

Subscriber Date of Birth: _____

Relationship to patient: _____

Group/Policy # _____ Division # _____

ID/Certificate # _____

Insurance Company: _____

Employer Name: _____

PATIENT CERTIFICATION & APPROVAL - I the undersigned, certify that all the above medical & dental information is true to the best of my knowledge and I have not omitted any pertinent information.

PATIENT CONSENT/PRIVACY CODE - I the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for the fees associated with these procedures. I have reviewed how your office will use my personal information (patient contact, specialist referrals, office promotions...) and the steps your office is taking 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. Virgulti can collect, use and disclose this personal information as set out in the information about the office's privacy policies.

Date: _____ Print Name: _____ Signature: _____