

# WELCOME TO LIFETIME DENTAL

Name: Mr./Miss/Mrs./Ms./Dr. \_\_\_\_\_ Today's date: \_\_\_\_\_  
Last First Middle initial day/month/year

Address: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
Number Street Apt

E-mail address: \_\_\_\_\_  
City Province Postal Code

Birth date: \_\_\_\_\_  
day/month/year

Phone (home): \_\_\_\_\_ (work): \_\_\_\_\_ ext: \_\_\_\_\_ Cell: \_\_\_\_\_

Person responsible for account:  Self  Other: \_\_\_\_\_

Do you have dental benefits?  Yes  No

Insurance company: \_\_\_\_\_ Group Policy #: \_\_\_\_\_

Preferred appointment times:  Any  Morning  Afternoon  Evening  M  T  W  Th  F

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Family Physician: \_\_\_\_\_

In case of emergency please notify – Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

Referred by: Another Patient/Family or Friend? (name) \_\_\_\_\_

Yellow Pages Book/Internet  Website/Internet  Flyer  Other: \_\_\_\_\_

## MEDICAL HISTORY

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. Please fill in the entire form.

1. Are you in good health? .....  Yes  No

2. Has there been any change in your general health in the past year? .....  Yes  No

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

3. Are you currently taking any medication, non-prescription drugs or herbal supplements of any kind? .....  Yes  No

Please specify medications: \_\_\_\_\_

4. Do you have any allergies? (e.g. penicillin, latex/rubber product) .....  Yes  No

Others please specify: \_\_\_\_\_

5. Have you ever had a peculiar or adverse reaction to any medicines or injections? .....  Yes  No

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

6. Do you bleed or bruise easily? .....  Yes  No

7. Do you have a heart problem of any kind? .....  Yes  No

Explain: \_\_\_\_\_

8. Have you ever had a heart murmur, mitral valve prolapse or rheumatic fever .....  Yes  No

9. Have you ever been advised by your doctor to take antibiotics before dental treatment? .....  Yes  No

10. Have you ever been exposed to Hepatitis or Jaundice? .....  Yes  No

11. Women only: Are you pregnant or breast-feeding? .....  Yes  No

12. Have you ever been hospitalized for any illness or operations? .....  Yes  No

Explain: \_\_\_\_\_

- |  |   |  |  |
|--|---|--|--|
| Do you have or have you ever had any of the following? | <input type="checkbox"/> Cancer             | <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Stomach ulcer               |
|  | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Hip replacement surgery | <input type="checkbox"/> Stroke                      |
| Please check those that apply.                         | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Knee replacement        | <input type="checkbox"/> Thyroid problem             |
| <input type="checkbox"/> Aids                          | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Liver disease           | <input type="checkbox"/> Venereal disease            |
| <input type="checkbox"/> Arthritis/Rheumatism          | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Lung disease            | <input type="checkbox"/> Osteoporosis                |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Hay fever          | <input type="checkbox"/> Mental disorder         | <input type="checkbox"/> Artificial joint (knee/hip) |
| <input type="checkbox"/> Blood Disease                 | <input type="checkbox"/> Head injuries      | <input type="checkbox"/> Prosthetic heart valve  |  |

Are you currently taking bisphosphonate medication? .....  Yes  No

Have you ever had any illness not included above? .....  Yes  No

Specify \_\_\_\_\_

**DENTAL HISTORY**

1. Have you ever had a dental examination with a full series of x-rays of your teeth and jaws? .....  Yes  No
2. When was your last dental visit? \_\_\_\_\_
3. Have you ever had any complications/problems with past dental treatments? .....  Yes  No  
Please explain \_\_\_\_\_
4. Have you ever had any problems/reactions to local anaesthetic? .....  Yes  No
5. Are your teeth sensitive to:  
 Cold  Sweets  Heat  Other \_\_\_\_\_
6. Do your gums bleed when:  Brushing  Flossing  Spontaneously
7. Do your gums feel swollen or tender? .....  Yes  No
8. Does food lodge between your teeth? .....  Yes  No
9. Does your jaw crack, pop or grate when opened widely? .....  Yes  No
10. Do you grind or clench your teeth? .....  Yes  No
11. Reason for today's visit: Examination and cleaning? \_\_\_\_\_ Emergency or specific problem? \_\_\_\_\_  
Other? \_\_\_\_\_

**Office Policy (please read)**

We will help prepare insurance claim forms and assist in requesting reimbursements from insurance companies on behalf of our patients. Not all services may be covered by dental insurance and every plan has its own unique quirks and exceptions. We will do our best to help you clarify your plan. **However, it is the patient's responsibility to understand his or her own dental insurance benefits. Unless otherwise agreed upon, services are to be paid for at each visit as they are performed.**

Please help us in providing the very best of service by remembering that once you have made an appointment this time is reserved for you. Therefore, we require a minimum of **48 hours notice (2 business days)** if an appointment must be cancelled or rescheduled. **A fee may be charged for cancelled or missed appointment without sufficient notice.** Please note that insurance companies do not cover fees for broken appointments. Therefore such fees are the patient's responsibility.

I authorize Lifetime Dental to perform all dental or diagnostic procedures agreed to be necessary or advisable, including x-rays, photographs, and the use of local anaesthetic or other medications as indicated. I understand that if I miss an appointment or provide less than 48 hours notice to cancel or reschedule an appointment, I may be charged a cancellation fee. I assume full responsibility for fees associated with my dental treatment and those of my dependents. I have read and fully understand the above conditions of treatment and I accept my responsibility as a patient at this office.

\_\_\_\_\_  
Signature of patient, parent or guardian

Date: \_\_\_\_\_