THE BLOOR CLINIC DENTAL SPECIALTY GROUP

PATIENT INFORMATION **Date** ______________

First Name: ________________________ Last Name: ____________________________
Date of Birth: Month_______ Day______ Year______ Age: _____
Address: ____ Apt#: ________
City: __________________ Prov: __________________ Postal code: ______________
Home Phone: ____________________ Cell Phone: ____________________
May we call you at work? YES/NO Business Phone: _________________ Ext: _________
Email: ____
Health Card Number: ____
Family Physician: _______________________________ Phone:__________________
Medical Specialist: ______________________________ Phone:__________________
Referring Dentist: _______________________________ Phone:__________________

In case of emergency, contact ____
Relationship: ____________________________Phone:______________________
Closest family relative: ______________________Phone:______________________

Person responsible for account: Self □ Spouse □ Parent □ Other □
Do you have dental insurance: YES/NO Insurance Company: ____________________
Policy No: ________________ Certificate No:__________________ Div No:__________

Insurance Policy Holder's Information

First name: ______________ Last Name: _________________ D.O.B. ________________
Address: _____________________________ Unit #: ______ City/Prov: _______________
Postal Code: _____________ Phone: __________________ Employer:_______________
Do you have any other dental coverage: YES/NO ________________________________

HEALTH HISTORY

1) Are you being treated for any medical condition at the present time? YES/NO
2) Have you been treated within the past year? YES/NO
If yes, why? ____
3) When was your last medical check up? _______________________________________
4) Has there been any change in your general health in the past year? YES/NO
If yes, please explain. ____
5) Are you taking any medications, non-prescription drugs or herbal supplements? YES/NO
If yes, please list: 1. _________________ 2. __________________ 3. _______________
4. ________________ 5. _______________ 6. _________________ 7. ________________
6) Do you have any allergies? YES/NO
If yes, please list using the categories below:
□ Medications □ Latex/rubber products □ other (e.g. Hay fever, foods)
List: ____

7) Have you ever had a peculiar or adverse reaction to any medications or injections? YES/NO
If yes, please explain. ______________________________

8) Do you have or have you ever had asthma? YES/NO

9) Do you have or have you ever had any heart or blood pressure problems? YES/NO

10) Do you have or have you ever had the following? YES/NO

□ an artificial heart valve □ an infection of the heart (i.e. infective endocarditis)
□ a heart condition at birth (i.e. congenital heart disease) □ a heart transplant

11) Do you have a prosthetic or artificial joint? YES/NO If yes, year placed __________

12) Do you have any conditions or therapies that could affect your immune system? YES/NO

□ Leukemia □ AIDS □ HIV infection □ Radiotherapy □ Chemotherapy

13) Have you ever had Hepatitis, Jaundice, or Liver Disease? YES/NO

14) Do you have a bleeding disorder? YES/NO

15) Have you ever been hospitalized for any illness or operations? YES/NO
If yes, please explain. ______________________________

16) Have you or a family member ever had an adverse reaction to a general anesthetic? YES/NO

17) Do you bleed EXCESSIVELY from a cut or injury? YES/NO

18) INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR HAVE HAD.

□ chest pain	□ steroid therapy	□ seizures (epilepsy)	□ lung disease
□ liver disease	□ shortness of breath	□ emphysema	□ cancer
□ arthritis	□ diabetes	□ thyroid disease	□ pacemaker
□ rheumatic fever	□ stroke	□ stomach ulcer	□ tuberculosis
□ kidney disease	□ heart murmur	□ heart attack	□ eating disorder
□ psychiatric illness	□ sickle cell disease	□ osteoporosis medications	
□ heart rhythm disorder		□ mitral valve prolapse	
□ gastrointestinal disorder		□ alcohol/drug dependency	
□ malignant hyperthermia			

19) Are there any conditions or diseases not listed above you have or have had? YES/NO
If yes, what? ______________________________

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

21) Do you smoke or chew tobacco products? YES/NO

22) Are you nervous during dental treatment? YES/NO

23) FOR WOMEN ONLY: Are you pregnant or breastfeeding? If pregnant,
what is the expected delivery date? ______________________________

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT.

Patient/Parent/Guardian Signature ______________________ Date __________

COMMENTS: ______________________________

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DENTAL SPECIALTY GROUP

Financial Consent Form for Insurance + Non-Insurance Clients

I________________________________ am aware of the office policy at The Bloor Clinic Dental Specialty Group. I understand and consent that payment is required upfront in full for all dental treatment. I understand even though I have or don't have dental insurance that I am personally responsible for the payment of services rendered at the time of treatment. I am aware that if I have insurance, my insurance company will reimburse me based on my plan coverage.

PLEASE NOTE CHEQUES OR E-TRANSFERS ARE NOT ACCEPTED

______________________	______________________	______________
Signature of Patient/Guardian	Witness	Date