Centre Street Family Dental Dr. Catherine Zacal

Patient Information

Patient name: First_____Last _____ Date:_____
Birth Date :_____ e-mail _____
Adress : Street _____appt #_____
City_____ Prov _____ Postal code _____
Phone : (cell)_____ (work) _____(ext)_____ best time to call _____
MALE _____ FEMALE _____ Marital satus_____ Spouse name_____

In case of emergency contact_____relation_____ph number_____
Are any other relatives patients here_____

DENTAL HISTORY

- Date of last dental visit_____ reason for this visit_____
- Is there a dental problem you want to have treated immediately?_____
- Have you ever had any complications during or following dental treatment YES NO
- If yes, please explain_____
- Are your teeth sensitive to : COLD_____ HEAT _____ SWEET _____
- Do your gums bleed when: Brushing_____ Flossing _____ Never _____
- Do you have bad breath or a bad taste in your mouth?_____
- Do your jaws crack, pop or grate when you open widely?_____
- Do you grind or clench your teeth?_____
- Do you have food catch between your teeth?_____
- Have you ever had local anaesthesia (freezing)_____ any complications?_____
- What is most important about your teeth?_____
- Are you satisfied with your teeth? Specify_____
- Have you noticed any loose or shifting teethe_____
- Are you tense during dental appointments? NOT 1 2 3 4 5 VERY

HEALTH INFORMATION

Have you ever had any of the following? Please CIRCLE all that apply:

○ AIDS	Excessive Bleeding	Liver disease	Stroke_____
○ Allergies_____	Fainting	Mental disorders	Tuberculosis
○ Anemia	Glaucoma	Nervous disorders	Tumours
○ Arthritis	Hepatitis A B C	Pacemaker	Ulcers
○ Artificial joints	Head injuries	Pregnancy	Venerial disease
○ Asthma	HIGH or LOW blood pressure	Radiation treatment	Penicllin allergy
○ Blood disease	Jaundice	Respiratory problems	Bacterial endocarditis
○ Cancer _____	Kidney disease	Rheumatic fever	Sinus problems
○ Diabetes	Lung disease	Thyroid disease	Inflammatory bowel
○ Dizziness	Lupus	Heart murmur	Heart attack_____
○ Epilepsy	Malignant hyperthermia	Heart disease	OTHER_____

- Have you been admitted to the hospital or needed emergency care in the past 2 years YES NO
_____
- Are you now under the care of a physician YES NO _____
- Name of Physician_____ phone number_____
- Are you taking any prescription or NON prescription drugs or SUPPLEMENTS?
- _____
_____

Have you ever had any adverse effect to any of the following: Antibiotic: Penicillin_____ Sulfonamide_____
Aspirin_____ Codeine_____ Local anaesthetic_____ LATEX_____ Sleeping pills_____ NONE_____
Do you smoke YES NO How much per day_____
Do you bruise easily or have prolonged bleeding YES NO
Do you have any other health problems that need clarification YES NO
Women: Are you pregnant? YES NO Due date_____

TO THE BEST OF MY KNOWLEDGE ALL OF THE PRECEIDNG ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH, I WILL INFORM THE DOCTORS AT THE NEXT APPOINTMENT.

Patient signature_____ Date_____
Dentist signature_____Date_____

**********REFERRAL INFORMATION*********

Whom may we thank for referring you to our practice? Another patient (name)_____
WEBSITE WORK SCHOOL YELLOW PAGES NEWSPAPER OTHER_____

EMPLOYMENT / INSURANCE INFORMATION

Employer_____ phone_____
Employer address_____ occupation_____

Primary insurance
Name of insured_____ date of birth_____
Insurance company_____
Policy / group #_____division_____
Employee ID #_____

Secondary Insurance
Name of insured_____ date of birth_____
Insurance company_____
Policy/ group #_____division_____
Employee ID # _____

We will submit insurance claims electronically where applicable. We do not deal with insurance companies directly. Please be familiar with your coverage and any updates as we do not have access to that information. Insurances only provide you with that information and any changes or updates to your insurance coverage.

FINANCIAL INFORMATION –(necessary to process invoices and apply payments)

Person responsible for this account? SELF SPOUSE OTHER_____
If OTHER, please provide address: _____postal code_____
Phone_____ employer_____

Consent for services:

I the undersigned certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have the opportunity to ask questions and receive answers to any questions about my health and dental history. I authorize the dentist to perform diagnostic procedures as may be necessary to determine needed treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised that the office has a privacy policy that I can review at any time, and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.
I authorize release to my dental benefits plan administrator and CDA, information contained in claims submitted electronically and agree that Dr. C. Zacal can collect, use and disclose personal information about myself as

_____ _____ _____
Signature of Patient, parent or guardian Relation to patient Date

_____ _____ _____
Signature of guarantor or payment Relation to patient Date