youngdentistry
SMILE CARE

New Patient Information Form

Personal Information

Name (first and last):		
Name you would like to be called:		Mr. Ms. Mrs. Miss. Dr. (circle one)
Home Address		**Contact Information**
Number and Street:		Home Phone:
Unit:	City:	Work Phone:
Postal Code:		Cell Phone:
Date of Birth (dd/mm/yyyy):		Email address:
Preferred method of communication (circle one): **Home Phone Work Phone Cell Phone Email Text**		Occupation:
Emergency Contact Name:		Emergency Contact Phone Number:
Relationship to Patient:		Family member responsible for this account:
How did you find out about us?		

Insurance Information

Name of policy holder (if different than above):		
Date of Birth (dd/mm/yyyy):		
Insurance Company:	Employer:	
Division (if applicable):	Policy/Group:	Certificate ID:
Name of policy holder of **secondary** insurance policy (if applicable):		
Date of Birth (dd/mm/yyyy):		
Insurance Company:	Employer:	
Division (if applicable):	Policy/Group:	Certificate ID:

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Medical Information

Physician:	Physician's location (eg. address or town):
Please list any medical conditions for which you are being treated or have been treated recently:	
Approximate date of last medical check-up:	

Please list any **medications** or **herbal supplements** you are currently taking:	
Medication	**Reason**

Do you have an allergy to any of the following (please check)?

❍ Penicillin	❍ Codeine	❍ Latex/Rubber	❍ Local Anesthetic
❍ Metals	❍ Sulfonamide	❍ Other:	

Please indicate if you have or have ever had any of the following conditions (please check):

❍ Blood Pressure Problems	❍ Stroke
❍ Pacemaker	❍ Chest Pain/Angina
❍ Heart Transplant	❍ Prosthetic Heart Valve
❍ Infective Endocarditis	❍ Congenital Heart Disease
❍ Other Heart Condition (explain):	
❍ Compromised Immune System (eg. HIV, AIDS, Leukemia)	
❍ Smoker or Former Smoker - How much?	How many years?
❍ Bleeding Problem or Bruise Easily	❍ Jaundice/Hepatitis/Liver Disease
❍ Osteoporosis	❍ Asthma
❍ Emphysema/COPD	❍ Artificial Joint (date of surgery):
❍ Alcohol/Drug Dependence	❍ Cocaine/Amphetamine Use
❍ Diabetes	❍ Stomach Ulcers
❍ Cancer (indicate type):	❍ Chemotherapy/Radiation
❍ Thyroid Problems	❍ Epilepsy
❍ Kidney Disease	❍ Tuberculosis
Female Patients	
❍ Currently Pregnant	❍ Currently Breast Feeding
Do you have any other medical conditions of which the dentist should be aware?	

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Dental Information

Previous Dentist:	Located in (town/city):
When was your last dental visit?	What treatment was provided?
When did you last have dental x-rays?	Cleaning?
How often do you have your teeth cleaned at the dentist?	
How often do you brush your teeth?	How often do you floss your teeth?
Do you have any specific concerns about your oral health? (explain)	

(For the following, please check yes or no)	**Yes**	**No**
Do you require antibiotic pre-medication prior to dental cleanings and/or procedures?		
Is there discomfort associated with any of your teeth?		
Do your gums bleed when you brush or floss?		
Do you find that you are susceptible to tooth decay?		
Do you clench or grind your teeth?		
Do you snore or have you been told you snore?		
Do you have any missing teeth that you would like to investigate replacing?		
Have you sustained any injury to your jaw (sports, motor vehicle accident etc.)?		
Are you interested in correcting crowded, spaced or misaligned teeth?		
Are you currently being treated by a dental specialist (periodontist, orthodontist etc.)?		
Would you like to learn more about whitening or cosmetic dentistry options?		
Rate your anxiety about dental appointments (circle one): **None** **Mild** **Moderate** **Severe**		
Please add anything else relevant about your dental history:		

General Consent statement: I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and have not knowingly ommited any information. I authorize the dentist to perform necessary diagnostic procedures and treatments to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

I give express consent to receiving commercial electronic messages from Young Dentistry. I understand my contact information will be protected and used only for communicating regarding my or my dependent's care.

I agree that Young Dentistry has obtained informed consent from me with respect to the collection, use and disclosure of my personal information. Upon my request, I have been provided with a copy of the Privacy Code and agree that personal information may be collected, used and disclosed as set out in the Code and is in accordance with the Personal Health Information Protection Act, 2004.

I am aware that **missing** an appointment or **failing to give two business days notice** for a cancellation may result in a cancellation **fee**.

Consent to Electronic Submission of Insurance Claims: I authorize release, to my benefits plan administer and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of service described to Young Dentistry. This authorization shall continue until the undersigned revokes the same.

Patient/Parent or Guardian Signature: ________________________________ Date: _______________