ERINGATE DENTAL CLINIC

450 Rathburn Road, Toronto, Ontario M9C 3S6
(416) 695-9372 • eringatedental.com

Have Healthy Teeth and Gums for Life

Medical Alert: _____

PATIENT INFORMATION

Welcome to Our Dental Office!
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.

PERSONAL INFORMATION

Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Last Name: _____
First Name: _____ Mid: _____ Preferred Name: _____
Status: Single ☐ Married ☐ Child ☐ Other ☐ Date of Birth (DD/MM/YY): _____/_____/_____
Home Address: _____ Apt: _____
City: _____ Postal Code: _____
Email: _____ Home Tel: _____
Work Tel: _____ Cell: _____
Employer: _____ Occupation: _____
Physician: _____ Physician's Phone No: _____
Previous Dentist: _____
How long have you been a patient? _____ Months/Years
Why have you decided to change dental offices? _____
How did you hear about us? _____
Are you available for short notice? Yes ☐ No ☐
Best method of contact: Call ☐ Text ☐ Email ☐

INSURANCE INFORMATION 1

Name of insured: _____
Employer: _____ Date of Birth of Insured (DD/MM/YY): _____/_____/_____
Insurance Company: _____ Policy/Group: _____
Division (If applicable): _____ Certificate ID#: _____
Do you have Secondary Insurance? Yes ☐ No ☐ Are you familiar with your plan details? Yes ☐ No ☐
Relationship: Self ☐ Spouse ☐ Other ☐

INSURANCE INFORMATION 2

Name of insured if different from above: _____
Employer: _____ Date of Birth of Insured (DD/MM/YY): _____/_____/_____
Insurance Company: _____ Policy/Group: _____
Division (If applicable): _____ Certificate ID#: _____
Relationship: Self ☐ Spouse ☐ Other ☐ Are you familiar with your plan details? Yes ☐ No ☐

EMERGENCY CONTACT

Name _____
Relationship: _____ Tel: _____

MEDICAL HISTORY

Doctor's Signature: _____ Date: _____

Patient Name: _____

Name of Physician/ and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

DO YOU HAVE or HAVE YOU EVER HAD:

1. Hospitalization for illness or injury _____ Y ☐ N ☐
2. An allergic reaction to

☐ Aspirin, ibuprofen, acetaminophen, codeine
☐ Penicillin
☐ Tetracycline
☐ Erythromycin
☐ Sulfa
☐ Local Anesthetic
☐ Fluoride
☐ Metal (nickel, gold, silver, _____
☐ Latex
☐ other_____

3. Heart problems, or cardiac stent within the last six months Y ☐ N ☐
4. History of infective endocarditis Y ☐ N ☐
5. Artificial heart valve, repaired heart defect (PFO) Y ☐ N ☐
6. Pacemaker or implantable defibrillator Y ☐ N ☐
7. Artificial prostheses (heart valve or joints) Y ☐ N ☐
8. Rheumatic or scarlet fever Y ☐ N ☐
9. High or low blood pressure Y ☐ N ☐
10. A stroke (taking blood thinners) Y ☐ N ☐
11. Anemia or other blood disorder
12. Prolonged bleeding due to a slight cut (INR>3.5) Y ☐ N ☐
13. Emphysema, shortness of breath, sarcoidosis Y ☐ N ☐
14. Tuberculosis, measles, chicken pox Y ☐ N ☐
15. Asthma Y ☐ N ☐
16. Breathing or sleep problems (i.e. sleep apnea, snoring, sinus) Y ☐ N ☐
17. Kidney disease Y ☐ N ☐
18. Liver disease Y ☐ N ☐
19. Jaundice Y ☐ N ☐
20. Thyroid, parathyroid disease, or calcium deficiency Y ☐ N ☐
21. Hormone deficiency Y ☐ N ☐
22. High cholesterol or taking statin drugs Y ☐ N ☐
23. Diabetes (HbA1c=_____) Y ☐ N ☐
24. Stomach or duodenal ulcer Y ☐ N ☐
25. Digestive disorders (i.e. celiac disease, gastric reflux) Y ☐ N ☐
26. Osteoporosis/ osteopenia (i.e. taking bisphosphonates) Y ☐ N ☐
27. Arthritis, rheumatoid arthritis, lupus Y ☐ N ☐
28. Glaucoma Y ☐ N ☐
29. Contact lenses Y ☐ N ☐
30. Head or neck injuries Y ☐ N ☐
31. Epilepsy, convulsions (seizures) Y ☐ N ☐
32. Neurologic disorders (ADD/ADHD, prion disease) Y ☐ N ☐
33. Viral infections and cold sores Y ☐ N ☐
34. Any lumps or swelling in the mouth Y ☐ N ☐
35. Hives, skin rash, hay fever Y ☐ N ☐
36. STI / STD Y ☐ N ☐
37. Hepatitis (type_____) Y ☐ N ☐
38. HIV / AIDS Y ☐ N ☐
39. Tumor, abnormal growth Y ☐ N ☐
40. Radiation therapy Y ☐ N ☐
41. Chemotherapy, immunosuppressive Y ☐ N ☐
42. Emotional problems Y ☐ N ☐
43. Psychiatric treatment Y ☐ N ☐
44. Antidepressant medication Y ☐ N ☐
45. Alcohol / street drug use

ARE YOU:

46. Presently being treated for any other illness Y ☐ N ☐
47. Aware of a change in your health in last 24 hrs (i.e. fever, chills, new cough, or diarrhea) Y ☐ N ☐
48. Taking medication for weight management (i.e. fen-phen) Y ☐ N ☐
49. Taking dietary supplements Y ☐ N ☐
50. Experiencing frequent headaches Y ☐ N ☐
51. Often exhausted or fatigued
52. A smoker, smoked previously or use smokeless tobacco Y ☐ N ☐
53. Considered a touchy person Y ☐ N ☐
54. Often unhappy or depressed Y ☐ N ☐
55. FEMALE - taking birth control pills Y ☐ N ☐
56. FEMALE - pregnant Y ☐ N ☐
57. MALE - prostate disorders Y ☐ N ☐

Describe any current medical treatment, impending surgery, genetic / development delay, or other treatment that may affect your dental treatment (i.e. Botox, Collagen injections)

_____

List all medication, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVICE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

DENTAL HISTORY

Doctor's Signature: _____ Date: _____

Patient Name: _____

How would you rate the condition of your mouth? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Date of most recent dental exam: _____/_____/_____ Date of most recent x-rays: _____/_____/_____

Date of most recent treatment (other than cleaning) _____/_____/_____

I routinely see my dentistry every: 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely ☐

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY:

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] Y ☐ N ☐
2. Have you had an unfavourable dental experience? Y ☐ N ☐
3. Have you ever had complications from past dental treatment? Y ☐ N ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? Y ☐ N ☐
5. Did you ever had braces, orthodontic treatment or had your bite adjusted? Y ☐ N ☐
6. Have you had any teeth removed? Y ☐ N ☐

GUM AND BONE:

7. Do your gums bleed or are they painful when brushing or flossing? Y ☐ N ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? Y ☐ N ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? Y ☐ N ☐
10. Is there anyone with a history of periodontal disease in your family? Y ☐ N ☐
11. Have you ever experienced gum recession? Y ☐ N ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating apple? Y ☐ N ☐
13. Have you experienced a burning sensation in your mouth? Y ☐ N ☐

TOOTH STRUCTURE:

14. Have you had any cavities within the past 3 years? Y ☐ N ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? Y ☐ N ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? Y ☐ N ☐
17. Are any teeth sensitive or hot, cold, biting, sweets, or avoid brushing any part of you mouth? Y ☐ N ☐
18. Do you have any grooves or notches on your teeth near the gum line? Y ☐ N ☐
19. Have you ever had broken teeth, or had a toothache or cracked filling? Y ☐ N ☐
20. Do you frequently get food caught between any teeth? Y ☐ N ☐

BITE AND JAW JOINT:

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, looking, popping) Y ☐ N ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? Y ☐ N ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? Y ☐ N ☐
24. Have your teeth changed in the past 5 years, become shorter, thinner or worn? Y ☐ N ☐
25. Are your teeth crowding or developing spaces? Y ☐ N ☐
26. Do you have more than one bite and squeeze to make your teeth fit together? Y ☐ N ☐
27. Do you chew ice, bite your nails, use you teeth to hold objects, or have any other oral habits? Y ☐ N ☐
28. Do you clench your teeth in the daytime or make them sore? Y ☐ N ☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth? Y ☐ N ☐
30. Do you wear or have you ever worn a bite appliance? Y ☐ N ☐

SMILE CHARACTERISTICS:

31. Is there anything about the appearance of your teeth that you would like to change? Y ☐ N ☐
32. Have you ever whitened (bleached) your teeth? Y ☐ N ☐
33. Have you ever felt uncomfortable or self conscience about the appearance of your teeth? Y ☐ N ☐
34. Have you been disappointed with the appearance of previous dental work? Y ☐ N ☐

PATIENT CONSENT FORM: COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

1. You will be asked about medical history, dental history, current and previous, chief complaint, and goals of the treatments. You will disclose the current accurate information to the best of your knowledge. This information will help us deliver safe and efficient dental care.
2. All fees are payable in full by the patient or parent/guardian at the time the service provided, we do not do direct billing. This means that your insurance cheque will go directly to you and not to you our office.
   If you provide us with your insurance information, we will be happy to submit the claims electronically on your behalf.
   For your convenience, we accept Visa, MasterCard or Debit.
3. All information you share is confidential, only necessary information is collected about you.
4. The doctor will only share your information with your consent.
5. Storage, retention and destruction of your personal information complies with existing legislation, and privacy. Privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons.
6. You have the right to deny use of any of our instruments. You have the right to ask all the questions about different procedures and getting them explained to you before they are conducted.
7. Collecting additional information such as, dental casts or impressions, x-ray or other means of imaging, photography, referral to other specialists such as and not limited to: Periodontists, Endodontists, Orthodontists, Oral Medicine, Oral Anesthesia, Maxillofacial Surgeon and Physician is needed to formulate accurate diagnoses and you will be informed about them as needed. You have the right to deny any of those data collection procedures.
8. You authorize photos and x-rays of your care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. Your identity will not be revealed to the general public without your permission.

CANCELLATION

If an unforeseen circumstance occurs and you need to change your appointment, we require at least a **TWO (2) BUSINESS-DAY NOTICE.** A charge of $75 may apply, which will not be covered by your insurance.

I have read and understood the above statements. I agree that I am responsible for all dental charges due on the day of my dental treatment.

Please email **appointment@eringatedental.com** when completed

Print Name	Signature
Date	Signature of Witness