Patient Dental History Dr. Elizabeth Watt

Legal name: ____ Preferred name: __________________
Date of Birth____________________________
Reason for Visit____ Referred by____________________________
Last dental visit______________________ Treatment provided at that time______________________________
Frequency of dental visits________________ Previous dentist (name and location) _______________________
Have you had a complete series of dental films/x-rays taken? ________ When? ___________________________
Location ______________________________________ Can we request these be sent to our office? _________

Please indicate Yes (Y) or No (N) to the following:

Do your gums bleed while brushing of flossing? ___
Are your teeth sensitive to hot or cold? ___
Do you feel pain in any of your teeth? ___
Do you have any sores or lumps in or near your mouth? ___
Have you ever had any head, neck, or jaw Injuries? ___

Do you bite your lips/cheeks frequently? ___
Have you noticed any loosening of your teeth? ___
Have you had periodontal (gum) treatment? ___
Have you received oral hygiene instruction for the care of your teeth and gums?___
Have you had prolonged bleeding following extractions? ___

Have you experienced any of the following problems?
Clicking ___
Pain (joint, ear or side of face) ___
Difficulty in opening or closing ___
Difficulty in chewing? ___
Do you have frequent headaches? ___
Do you clench or grind your teeth? ___

Do you wear dentures or partials? ______
if yes, date of placement _____________________
Do you have dental implants?_____
if yes, date of placement _____________________
Have you had orthodontic treatment? _____
if yes date of completing______________________
Have you had treatment from a dental specialist? ___
if yes what type? _____________________________

Additional comments or concerns? ____

____ ____

____ ____

Insurance Information: Policy holder: ___________________________ Relationship to patient: ____________________
Employer:___________________________ Work phone: _______________ Email: _________________________________
Address if different : ____
Insurance Company: _________________________ Group/Policy #: _______________Certificate/DIV/ID#: ___________
Coverage: Basic: ___% limit: $_______ Major: ___% limit: $ ________ Ortho___% limit $_______

Secondary Insurance: Policy holder: _________________________ Relationship to patient: ______________
Employer:___________________________ Work phone: _______________ Email: _________________________________
Address if different: ____
Insurance Company: _________________________ Group/Policy #: _______________Certificate/DIV/ID#: ___________
Coverage: Basic: ___% limit: $_______ Major: ___% limit: $ ________ Ortho___% limit $_______

__________________________________ ______________________
Patient's/Parent's/Guardian's signature Date

Confidential Medical History Dr. Elizabeth Watt_

Legal name: ___________________________________ email:____
Address:____
Phone number: ______________________ alternate phone number: ___________________
Are you in good health? Yes___ No___ If no, please provide details: ____
____
_____________________________________ ____
Physician: _________________________________Date of last medical examination? ______________________
Are you presently receiving treatment for any illness? ____
____ ____
Have you ever been hospitalized? _____ If yes, please provide details with dates__________________________
____ ____
____ _______________________________________
Do you have any heart or circulatory problems? Yes __ No___ Do you have a pacemaker? Yes___ No____
Please describe ____
Have you ever been advised to take antibiotic pre-medication prior to dental treatment? Yes___ No____
If yes, for what condition? ____
Do you have allergies to medications? Food? Seasonal hay fever? Other? Please List_______________________
___________________________ ____
Are you presently taking any kind of medication (please include over the counter medications)? Please list below:
Medication: _________________________ Reason: ____
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Medication: _________________________ Reason:____
Medication: _________________________ Reason: ____
Medication: _________________________ Reason: ____
Have you ever had a reaction to any kind of medicine or dental anesthetic? _____ If yes, please provide details:
____ ___________________________________
Are you pregnant, or think you may be pregnant? Yes__ No__ Breastfeeding? Yes__ No __

Please indicate below (√) if you presently have or have ever had any of the following (circle correct choice):

__AIDS/HIV	**__ Diabetes**	**__ Liver disease (Hepatitis/Jaundice)**
__Alcohol or chemical dependency	**__ Eating Disorders**	**__ Lung Disease/chest pains**
__Rheumatoid Arthritis/Osteoarthritis	**__Osteoporosis**	**__Mental or nervous disorder**
__ Artificial joints or valves	**__Fainting/dizzy spells**	**__ Autism Spectrum Disorder**
__ Asthma	**__ High/low pressure**	**__ Stroke**
__ Blood transfusion	**__ Hyper/hypo glycemia**	**__ Tuberculosis**
__Cancer/radiotherapy/chemotherapy	**__ Kidney disease**	**__ Viral infections/cold sores**
__High Cholesterol or taking statin drugs_	**__ Prolonged bleeding**	**__Thyroid disorder_______________**
__Head or neck injury	**__Digestive disorders/reflux**	**__Glaucoma**
__Breathing or sleeping problems	**__ Epilepsy/seizures**	**__STI/STD_____________________**
__Reflux/GERD		

Do you smoke? If yes, how much per day? ________________ per week? ____________________
Please list any additional medical information: ____
____ ____
__________________________________ ____
_______________________________________ ____

_____________________________________ ____________________
Patient/Parent/Guardian Signature **Date**

Office Policies

Insurance

As a service to you, our office will submit an insurance claim for payment to your dental insurance company to reimburse you. Subscriber information is required to obtain payment from your insurance company. Confirmation of coverage and eligibility may be required for service. Our office reserves the right to decide whether we will transact with, submit claims to, or process claims to any assigned dental insurance, or to a dental insurance plan with which we are not a provider. A dental insurance plan is between a policy holder and the insurance company. For this reason, we are often unable to communicate directly with your plan provider. It is the account holder's responsibility to understand the coverage and benefits of the patient's dental plan.

Payments

We Accept Mastercard, Visa, Debit, Cheque and cash to best serve you. Unless otherwise arranged, payment is expected upon completion of treatment. Multi-visit service appointments require portioned amounts to help cover any work performed, lab fees, expenses, supplies and materials used during treatment. Any remaining portion is expected at the completion visit.

Missed Appointments

Our office requires a minimum of 2 business days to reschedule or cancel an appointment. Please be aware that this time has been specifically reserved for you and a fee may be incurred if we receive insufficient notice. The fee for a missed appointment with the dentist or hygienist is $100.00 per hour. Please be aware that we review each situation individually the fee may be waived if circumstances dictate. We do our best to contact patients, usually by email, to remind them of upcoming appointments but respectfully ask that you create a reminder of your own and confirm your schedule.

Signature of Responsible Party________________________________ Date_____________

Printed name of Responsible Party_____________________________