West Bowmanville Family Dental

Patient Contact Information

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr

First Name: _____ Last Name: _____ Date of Birth: _____/_____/_____
DD MM YY

Address: _____ Apt/Unit # _____ City: _____ Postal Code: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Preferred Contact Method: _____

Emergency Contact Person: _____ Phone Number: _____

Insurance Information

Primary Insurance Company

Name of Policy Holder: _____ Date of Birth: _____/_____/_____
DD MM YY

Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Employer: _____ Name of Insurance Company: _____

Secondary Insurance Company (if applicable)

Name of Policy Holder: _____ Date of Birth: _____/_____/_____
DD MM YY

Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Employer: _____ Name of Insurance Company: _____

I, understand, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Margolian all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Bishara to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Authorized Signature: _____

* All fees or balances not covered by your dental insurance policy will be payable at time of visit. You must provide us with all insurance information. We do not have access to your private insurance policy information unless provided to us.

Referral Information

How did you hear about us?

☐ Facebook ☐ Internet Search ☐ Website ☐ Referral

Family Member or Friend: _____

Other: _____

Turn over →

Dental History

Please check any of the following that may apply to you:

- ☐ Sensitivity
- ☐ Tooth Pain or Discomfort While Chewing
- ☐ Headaches, earaches, or neck pain
- ☐ Jaw Joint Pain (clicking/cracking)
- ☐ Broken Teeth or Fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose or shifting teeth
- ☐ Bad breath or taste in the mouth

When was your last dental visit? _____ What was done at that visit? _____

When having dental treatment do you require sedation? ☐ nitrous oxide (laughing gas) ☐ oral medication

Do you smoke or chew tobacco? _____ If "yes" for how long? _____

If you could change your smile, you would…

- ☐ Make your teeth brighter/whiter
- ☐ Make your teeth straighter
- ☐ Close spaces
- ☐ Replace fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace crowns
- ☐ Have a smile makeover
- ☐ Other: _____

What is the most important thing to you about your visit today? _____

Medical History

Please check any of the following that apply to you:

☐ AIDS	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Allergies	☐ Emphysema	☐ HIV Positive	☐ Seizures
☐ Anaemia	☐ Excessive Bleeding	☐ Jaundice	☐ Snoring/Sleep Apnoea
☐ Arthritis	☐ Fainting	☐ Kidney Disease	☐ Stomach Problems
☐ Artifical Joints	☐ Glaucoma	☐ Liver Disease	☐ Stroke
☐ Asthma	☐ Heart Conditions	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Blood Disorders	☐ Heart Murmur	☐ Pacemaker	☐ Tuberculosis
☐ Cancer	☐ Heart Disease	☐ Pregnant	☐ Ulcers
☐ Chemotherapy	☐ Hepatitis A, B or C	☐ Respiratory Problems	☐ Other _____

Do you have any allergies?

☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Sulpha Drugs ☐ Local Aesthetic ☐ Latex ☐ Other _____

Current medications? _____

Do you have any joint replacements? _____ Do you require pre-medication for dental work? _____

Are you currently under a physician's care? _____ For? _____

Physician's Name and Phone Number: _____

Pharmacy's Name and Phone Number: _____

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 omitted any information. If required, I consent to my physician being contacted regarding any specific medical questions. I authorize Dr. Bishara to perform necessary diagnostic procedures and treatment as required to achieve proper care

We require at least 48 hours notice for cancellations or a *$50.00* cancellation fee will be applied. Please sign to show you have read and understand our policy:

Patient Signature: _____ Dentist's Signature: _____