In an effort to serve you better, we ask that you please provide the following information.
We are happy to offer any assistance you may require.
PLEASE PRINT.

Patient Information

A parent or guardian will be responsible for decisions regarding my treatment. ☐ Yes ☐ No

Name: Mr/Mrs/Ms/Miss/Dr _____
Last First Middle

Date of Birth: _____/_____/_____ Gender: _____
Day Month Year Male/Female/Other

Address: _____
Street Apt. City Prov Postal Code

Home Phone: _____ Cell Phone: _____

Email Address: _____

Best way to communicate with you: _____
(text, email, etc)

Emergency Contact: _____ Tel: _____
Name & Relationship

Family Physician: _____ Tel: _____

MHSC#: _____ PHIN #: _____

Insurance Information

Primary Insurance Company: _____

Group Policy #: _____ Division #: _____ Contract/ID: _____

Plan Holder Name: _____ DOB: _____
Day / Month / Year

Secondary Insurance Company: _____

Group Policy #: _____ Division #: _____ Contract/ID: _____

Plan Holder Name: _____ DOB: _____
Day / Month / Year

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. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain.

☐Yes ☐No ☐Not Sure/Maybe _____

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? If yes, please explain. ☐Yes ☐No ☐Not Sure/Maybe

_____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them.

☐Yes ☐No ☐Not Sure/Maybe _____

5. Do you have any allergies? If yes, please list them using the categories below: ☐Yes ☐No ☐Not Sure/Maybe

a) Medications: _____

b) Latex/rubber products: _____

c) Other (e.g. seasonal/environmental, foods): _____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

☐Yes ☐No ☐Not Sure/Maybe _____

7. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ☐Yes ☐No ☐Not Sure/Maybe

8. Have you ever had hepatitis, jaundice or liver disease? ☐Yes ☐No ☐Not Sure/Maybe

9. Do you have a bleeding problem or bleeding disorder? ☐Yes ☐No ☐Not Sure/Maybe

10. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ☐Yes ☐No ☐Not Sure/Maybe

_____

11. Do you have or have you ever had any of the following? Please check.

☐arthritis	☐asthma	☐cancer	☐chest pain, angina	☐diabetes	☐drug/alcohol/cannabis use or dependency
☐epilepsy	☐heart attack	☐heart murmur	☐heart or blood pressure problems	☐kidney disease	☐lung disease
☐mitral valve prolapse	☐osteoporosis medications	☐pacemaker	☐prosthetic or artificial joint	☐rheumatic fever	☐shortness of breath
☐steroid therapy	☐stomach ulcers	☐stroke, TIA	☐thyroid disease	☐tuberculosis	

12. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.

☐Yes ☐No ☐Not Sure/Maybe _____

13. Do you smoke or chew tobacco products? ☐Yes ☐No ☐Not Sure/Maybe

14. Are you nervous during dental treatment? ☐Yes ☐No ☐Not Sure/Maybe

15. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

☐Yes ☐No ☐Not Sure/Maybe _____

16. Do you identify as a patient with a disability? If yes, please explain. ☐Yes ☐No ☐Not Sure/Maybe

_____

How did you hear about our clinic? _____

I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment of dental diagnostic procedures. Our office policy requires that services are paid for at each visit as they are performed, we do not direct bill. Insurance is the responsibility of the patient, however should you require any assistance please notify our office staff and we will be happy to help. **If you are unable to keep an appointment, we require 24 hours notice, otherwise it may be necessary to charge for the time lost.**

I understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I give Chancellor Dental Group permission to electronically submit any claims or estimates to my insurance company on my behalf.

_____ _____ _____

Signature Print Date

☐Patient ☐Parent/Guardian