Bonnie Doon Dental Associates New Patient Intake Form

INSURANCE COMPANY:_____ POLCY/GROUP:_____ ID#:_____

PERSONAL INFORMATION (Please Print)	
(Circle) Mr. Mrs. Miss. Ms. Name:_____ (First) (Last) (Middle) Date of Birth _____-_____-_____ D M Y Male ☐ Female ☐ X – Another Gender ☐ Mailing Address _____ City_____ Province _____ Postal Code _____ Phone: Home_____ Cell _____ Work _____ Ext _____ Occupation _____ Email Address _____	Marital Status _____ Name of Spouse _____ Spouses Date of Birth _____-_____-_____ D M Y Emergency contact _____ Phone # _____ If Patient is a minor, who is legally responsible? _____ Is another member of your family or relative a patient at our office? If so, who? _____ Whom may we thank for referring you? _____

Please Circle

Yes No I consent to the performing of dental procedures agreed to be necessary.

Yes No I consent to recall and continuing care reminders (phone, email and/or text message).

Yes No I understand that responsibility for payment of fees associated with dental services (in whole or any portion not covered by my insurance) is mine, due and payable at the time services are rendered unless other arrangements have been made, including any assessment for short notice cancellations for hygiene appointments.

Yes No I permit Bonnie Doon Dental Associates to submit pre-authorization to my dental benefits plan administrator for dental Exams, procedures and routine care appointments.

Yes No I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically. I hereby assign my benefits, payable from claims submitted electronically to Bonnie Doon Dental Associates and authorize payment directly to them. This authorization shall continue in effect until the undersigned revokes the same.

Signature: _____ Date: _____

MEDICAL HISTORY (**Please Circle)**

The following information is required to thoroughly diagnose any condition and to give the highest possible standard of professional services. All information will be kept strictly confidential.

1. Yes No Are you currently in good health?
   Date of your last medical examination: _____
2. Yes No Are you under the care of a physician?
   If so, what is the condition being treated? _____
3. Yes No Have you had any serious illness/operation/ or been hospitalized?
   If so, please specify: _____
4. Yes No Are you taking any drugs or medications (prescription or non-prescription)? If so, please specify
   Name of drug/medication:
   _____For _____ _____For _____
   _____For _____ _____For _____
   _____For _____ _____For _____
5. Yes No Are you allergic or have you reacted adversely to any drug or medicine? I.e. local anesthetic (Freezing); penicillin, erythromycin or other antibiotics; barbiturates, sedatives, analgesics (Pain killers) i.e. codeine, ibuprofen? If so, please specify:
   _____
6. Yes No Do you have any allergies? If so, please specify _____

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7. Do you presently or have you ever had: (**Please circles YES or NO**)

AIDS/HIV **YES / NO**	Cancer **YES / NO**	Hepatitis A / B /C / D / E **YES / NO**	Liver Disease **YES / NO**	Scarlet Fever **YES / NO**
Anemia **YES / NO**	Diabetes **YES / NO**	Hemorrhage Problems **YES / NO**	Lung Disease **YES / NO**	Sinus Trouble **YES / NO**
Arthritis **YES / NO**	Epilepsy **YES / NO**	High/Low Blood Pressure **YES / NO**	Mental/Nervous Disorders **YES / NO**	Stomach (Intestinal) Ulcer **YES / NO**
Asthma **YES / NO**	Hay Fever **YES / NO**	Hyper/Hype Glycaemia **YES / NO**	Migraine Headaches **YES / NO**	Stroke **YES / NO**
Bladder Infection **YES / NO**	Heart Murmur **YES / NO**	Joint Replacement **YES / NO**	Rheumatic Fever **YES / NO**	Thyroid Problems **YES / NO**
Blood Disorder **YES / NO**	Heart Problems **YES / NO**	Kidney Disease **YES / NO**	Rheumatism **YES / NO**	Tuberculosis **YES / NO**

8. Yes No Do you bruise easily or have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
9. Yes No Have you ever had radiation treatment? (i.e. Cancer)
10. Yes No Have you ever taken cortisone or steroids?
11. Yes No Is there any history of family disease?
    If so, please specify _____
12. Yes No Do you have any disease or problem not listed above you think we should know about?
    _____
13. Yes No Are you pregnant or nursing? _____

Med History Reviewed By: Dr._____ Date: _____

DENTAL HISTORY (please circle)

1. Yes No How frequently do you see your dentist/ dental hygienist?
   ☐6 months ☐Yearly ☐Other_____ Last Dental _____Previous Dentist_____
2. Yes No Have you ever been given oral hygiene instruction in: ☐Brushing ☐Flossing ☐Other_____
3. How often do you brush your teeth? _____
4. How often do you floss your teeth? _____
5. Yes No Are any of your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Chewing ☐Other
6. Yes No Do your gums bleed when: ☐Brushing ☐ Flossing ☐ Spontaneously
7. Yes No Do your gums feel swollen or tender?
8. Do you breathe usually through your mouth _____ or nose _____
9. Yes No Are you aware of any loose teeth? If so, which one(s) _____
10. Yes No Does your jaw crack, pop or grate when you open widely?
11. Yes No Do you grind your teeth or clench your teeth, or bite your nails (please circle which one(s))
12. Yes No Have you ever had injuries to your face or jaw?
13. Yes No Have you had your tonsils _____ or adenoids_____ removed?
14. Yes No (Children only) Does your child have a thumb sucking habit or other habits? _____
15. How satisfied are you with the appearance or your teeth?
    (Low) 1 2 3 4 5 6 7 8 9 10 (High) If below a 5, please specify why
    _____
16. Yes No Have you ever had any problem associated with any previous dental experience?
17. Please rate your level of anxiety towards dental visits from 1 (low) to 10 (high): _____
18. Yes No Are you a regular consumer of tobacco, vape products, cannabis, alcohol, coffee or tea?
    (Please circle which one(s))
    If so, how much do you consume on a daily basis? _____
19. What dental condition concerns you at the present?_____
    _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medication changes, I will inform the dental staff at the next appointment without fail.

*Patient (Guardian) Signature: _____ Date: _____