Side 'A' **File #:** ___________ **Please also complete and sign Side 'B'**

Confidential Patient Information

Disponible en Français

If you have questions or need help completing this form please ask us

Your cooperation in completing both sides of this form is essential to help us provide you with the highest possible standard of dental care. All information is strictly confidential, **in accordance with our privacy policy (Patient Consent Form) attached,** and will remain in this office.

Name: (Mr. /Miss/Mrs. /Ms. /Dr.): **Last Name:** ______________ **First Name:** ______________

Date Of Birth (Day/Month/Year): ______________ **Sex:** ☐ Male ☐ Female

Address (Home)**:** Apartment and Street: ______________ City: ________ Postal Code: ________

Address (Business)**:** Apartment and Street: ______________ City: ________ Postal Code: ________

Phone (Home)**:** ______________ **Phone** (Business)**:** ______________

E-Mail Address: ______________

Occupation: ______________ **Employer:** ______________

How would you prefer your appointments to be confirmed: ☐ By Phone ☐ By email

Whom may we thank for referring you to our Clinic? ______________

This form is completed for: ☐ Self ☐ Dependant

Dental Insurance? ☐ Yes ☐ No

If 'Yes' please indicate the following:

Name of the insurance company 1: ______________

Policy #1: ______________

Certificate/ ID #: ______________

Name of the insurance company 2: ______________

Policy Number 2: ______________

Certificate/ ID #: ______________

Who is responsible for the payment? ☐ ***Myself*** ☐ ***My guarantor***

Preferred method of payment:

☐ ***Cash*** ☐ ***Debit (Interac)***

☐ ***VISA #:*** ______________

☐ ***M.C. #:*** ______________

☐ ***AMEX #:*** ______________

Expiry Date(s): ______________

MEDICAL HISTORY

Indicate which of the following you presently have or had: Y: Yes, N: No, NS: Not Sure

Condition	Y	N	NS	Condition	Y	N	NS	Condition	Y	N	NS
A.I.D.S.				Head/Neck Injuries				Mental/Nervous Disorder			
Anemia				Heart Disease or Attack				Mitral Valve Prolapse			
Angina Pectoris				Heart Murmur				Organ Transplant/Medical Implant			
Arthritis				Heart Pacemaker				Psychiatric Treatment			
Artificial Heart Valve				Heart Rhythm Disorder				Radiation Treatment/Chemotherapy			
Artificial Joint: Hip, Knee				Heart Surgery				Rheumatic/Scarlet Fever			
Asthma				Hepatitis A				Sickle Cell Disease			
Blood Disorders				Hepatitis B				Sinus Trouble			
Bronchitis				Hepatitis C				Stomach/Intestine Problems			
Cancer				Herpes				Stroke			
Congenital Heart Lesions				High/Low Blood Pressure				Thyroid Disease			
Cortisone/Steroid				Hodgkin's Disease				Tuberculosis			
Diabetes				Hyper (Hypo) Glycemia				Ulcer			
Emphysema				Hypertension				Other: ________			
Fainting or Dizzy Spells				Jaundice				**Allergies to:** Penicillin			
Glandular Disorders				Kidney Disease				Codeine			
Glaucoma				Liver Disease				Latex / rubber			
Epilepsy or Seizures				Lung Disease				Other: ________			
Pneumonia				Malignant Hyperthermia							

Question	Y	N	NS
Do you have any Drug / alcohol dependency?			
Have you been hospitalized for any reason or under medical care in the past 2 years?			
Have you ever been advised by your doctor to take antibiotics before dental treatment?			
Have you ever had a peculiar or adverse reaction to any medicines or injections?			

Side 'B' Medical history ... Continued Patient Name: ______________________

Women Only: Are you pregnant or suspect you may be? ☐ Yes ☐ No
If yes, What is the expected date?
Are you taking Birth Control Pills? ☐ Yes ☐ No
Are you breast-Feeding? ☐ Yes ☐ No

Has the **Child Patient** recently had any of the following (indicate approximate date): Please Circle
Tonsillitis Measles Chicken Pox Mumps Strep Throat

In case of emergency we should notify:

Contact Name: ______________ **Number:** ______________ **Relationship:** ______________

Name of the Physician: ______________ **Telephone # of the Physician:** ______________

Do you currently have, have you had in the Past any disease, condition or problem not listed above? If yes, please indicate:

Are you taking any medication currently? If yes please list medication name(s): ______________

It is important that any change in your health status be reported to our office

Do you wish to speak to the Doctor Privately about any problem or medical condition? ______________

DENTAL HISTORY

Have you been under regular care by any dentist? If yes please indicate:
Date Of Visit: ______________ **Dentist's Name:** ______________ **Dentist's Phone:** ______________

What was done at this time: ______________

Y: Yes, N: No

Condition	Y	N	Condition	Y	N
Do you have tender, swollen or bleeding gums?			Are your aware of any lump or swelling in your mouth?		
Do you wish to keep your natural teeth			Have you ever had a problem with local or general anesthetic?		
Do you smoke or chew tobacco products?			Interested in improving the appearance of your teeth?		
Do you get nervous during dental treatment?			Interested in whitening your teeth?		

Describe in your own words what would you like done with your teeth: ______________

Do you currently experience any of the following: Please check the box(s) corresponding to the relevant condition(s)

Loose Teeth		Neck Pain		Unexpected Nose Bleed		Popping or Clicking Jaw Joints	
Sensitive Teeth		Headache		Other:		Unsatisfactory Dentures	
Missing or Crooked Teeth		Ear Ache		Other:		Gagging	

Office Policy:
Your appointment time will be reserved for you. **If you are unable to keep the appointment we require 48 hours notice. Otherwise it may be necessary to charge for the time lost. Office policy is that services are paid for at each visit as they are performed. However, in certain circumstances arrangements for payment may be made by consulting the doctor.**

Patient Release:
I, the undersigned, certify that I have provided an accurate and **complete account of my personal and medical-Dental history and I have not knowingly omitted any information** . I have had the opportunity to ask questions and receive answers to any questions regarding my medical–dental history. I confirm that I have read, understood and agree to the entire content of the ' **Patient Consent Document'** attached to this form. **I authorize the dentist to perform denta l procedures** agreed to be necessary or advisable for proper dental care. I understand that **responsibility of payment** for the dental services provided for myself or my dependents is mine, and I will assume responsibility for fees associated with these services.

PATIENT/PARENT/GUARDIAN SIGNATURE: ______________ DATE: ______________
DENTIST SIGNATURE: ______________ DATE: ______________

Welcome to Apple's Dental Clinics and thank you for your referrals