Last Name: _____ Mr. Mrs. Ms. Dr. Birth Date: _____

First Name: _____ Weight: _____kg/lbs Age: _____

Home Address: _____

City: _____ Postal Code _____

Email: _____

Home Phone # (_____) _____-_____ Cell Phone #(_____) _____-_____

Work Phone # (_____) _____-_____Ext.___Other Phone #(_____) _____-___

WHAT IS THE BEST WAY TO REACH YOU? Home / Cell / Work / Email

Employer Name: _____Occupation: _____

Physician Name: _____Telephone: (_____) _____-_____

In Case of Emergency Notify: _____Relationship: _____

Telephone #: (_____) _____-_____

How did you hear about our office?

Website ParkPlace Junior Sign Google Brampton Guardian Facebook Instagram

Other _____

From Existing Patient If so, who? We would like to thank them! _____

Last dental visit: _____What was done at last visit: _____

What are your present dental concerns? Specific area _____Full exam _____

Details_____

bleeding gums	crooked teeth	broken teeth	poor smile
loose teeth	swollen gums	tooth ache	missing teeth
spaced teeth	worn teeth	discoloured teeth	loose dentures

(please complete other side)

MEDICAL HISTORY

Most recent physician exam _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

List all ***MEDICATIONS*** supplements, and/or vitamins taken within the last 2 years: _____

PLEASE CHECK THE CIRCLE
IF YOU HAVE OR EVER HAD:

Hospitalization for illness or injury

ALLERGIC reaction to:

- o Aspirin, ibuprofen, acetaminophen, codeine
- o Penicillin
- o Clindamycin
- o Local anaesthetic
- o Metals
- o Latex
- o Other: _____

- o Heart problems
- o Chest pain
- o Shortness of breath
- o Swollen ankles
- o Angina/Heart attack
- o Stroke
- o Heart murmur
- o Heart Surgery
- o History of infective endocarditis
- o Artificial heart valve, repaired heart defect, cardiac stent in last 6 months
- o Pacemaker
- o Heart failure
- o Mitral valve problems
- o Congenital heart disease

- o High or low blood pressure
- o Rheumatic/scarlet fever
- o Joint replacement
- o Anemia or other blood disorders
- o Prolonged bleeding due to small cut
- o Pneumonia, emphysema, shortness of breath, sarcoidosis
- o Tuberculosis
- o Asthma
- o Breathing or sleep problems
- o Kidney disease
- o Liver disease, Jaundice
- o Thyroid, parathyroid or calcium deficiency
- o High cholesterol
- o Diabetes (HbA1c : _____ Date: _____)
- o Stomach ulcers ,digestive or eating disorders (i.e. celiac disease, gastric reflux, bulimia, anorexia)
- o Osteoporosis/osteopenia (i.e taking bisphosphonates)
- o Arthritis
- o Autoimmune disease (rheumatoid arthritis, lupus, scleroderma)
- o Head or neck injuries
- o Epilepsy, convulsions (seizures)
- o STI/STD/HPV
- o Hepatitis (type _____)
- o HIV/AIDS
- o Tumor, abnormal growth, cancer
- o Radiation therapy
- o Chemotherapy
- o Psychiatric treatment
- o Antidepressant medication

PLEASE CHECK THE CIRCLE IF YOU ARE:

- o Presently being treated for any other illness;

If yes, list: _____

- o Aware of changes to your health in the last 24 hours: _____
- o Experiencing headaches
- o Smoker, smoked previously, or used smokeless tobacco

  Never Not Now Yes -- How many? _____cigs/day How long? ___ years
- o Drink alcohol

No/Occasionally Yes—How many? ___oz/day How long? ___ years

- o Recreational drug user: _____

FOR WOMEN

- o ***CURENTLY PREGNANT*** or planning a pregnancy?
- o Taking birth control

PLEASE ADVISE US OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS.

Signature_____ Date _____

PARKPLACE DENTAL CENTRE FD REVIEWED_____
110 QUEEN STREET EAST BRAMPTON L6V 1B1

PAYMENT FOR SERVICES PROVIDED INSURANCE INFORMATION OFFICE POLICIES

Patients are responsible for paying for any treatment rendered. Payment methods include Visa, Master Card, Amex, Debit, Cash and Cheque and e-transfer.

It is the responsibility of the Subscriber/Patient to understand what is covered under their insurance policy. This is an agreement between you, your employer and your insurance company. Not the dental office. We are happy to provide your insurance with estimates so that you can confirm your coverage.
Please ask if you have any questions.

(Please circle one)

YES, I would like to allow my insurance to pay the office. I understand that I am responsible for any fees the insurance company does not cover in relation to my treatment. I will pay for the difference not covered at the end of each appointment.

NO, I would like my insurance to reimburse me directly. I will pay for my treatment at the end of each appointment.

Primary Insurance	**Secondary Insurance**
Insurance Company_____	Insurance Company_____
Policy holder's Name_____	Policy holder's Name_____
Policy Holder's Date of Birth_____	Policy Holder's Date of Birth_____
Relation to Policy Holder (please circle one):	Relation to Policy Holder (please circle one):
Self/Spouse / Child / Dependant / Common Law	Self/Spouse / Child / Dependant / Common Law
Policy/Group #_____	Policy/Group #_____
ID/Certificate # _____	ID/Certificate # _____

Please Review—Office Policies

Accounts must be at a 0 balance before attending future visits

2% interest charges on accounts 60-days overdue

We ask that you provide our office two (2) business days notice when changing or canceling your appointment. Insufficient notice may result in a $50 cancelation charge to your account.

Thank you for your co operation

Name _____

Signature _____Date_____