

WELCOME TO OUR OFFICE



Dr. Samson Lee
Credit River Dental Centre

The following information is required by the Dentist to assist in proper diagnosis and treatment. Please feel free to ask the receptionist for help in completing this form. *PLEASE PRINT.*

114 Lakeshore Rd. E.
Port Credit, ON L5G 1E4
T: (905) 278 - 4297

ALL INFORMATION IS STRICTLY CONFIDENTIAL

Date (M/D/Y) _____

ADULT PATIENT or PARENT/GUARDIAN (if child see below) Dr. Mr. Mrs. Miss Ms.

Are you the: PATIENT PARENT GUARDIAN

Name: _____
(last) (first) (initial)

Address: _____
(apt./suite #) (street) (city) (province) (postal code)

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
(month/day/year)

Home Phone: () _____ Employer: _____

Cel Phone: () _____ Occupation: _____

E-Mail: _____ Work Phone: () _____ (ext)

CHILD or ADULT UNDER GUARDIANSHIP (if Patient)

Name: _____
(last) (first) (initial) (prefers to be called)

Address: _____
(if different) (apt./suite #) (street) (city) (province) (postal code)

Date of Birth: _____ Age: _____ Sex: _____ Grade: _____
(month/day/year)

Home Phone: () _____ School: _____
(if different)

HOW DID YOU HEAR ABOUT US?

Walk By Yellow Pages Index/Pink Pages Ad/Promotion Internet Referral (name) _____

Family Physician: _____ Phone: () _____

Address: _____
(suite #) (street) (city) (province) (postal code)

Medical Specialist: _____ Phone: () _____

Emergency Contact: _____
(last) (first) (initial) (relationship)

Occupation: _____ Employer: _____ Phone: () _____ (ext)

Closest relative: _____ Phone: () _____

Is another family member a patient at our office? _____

PERSON RESPONSIBLE FOR ACCOUNT: Self Guardian Spouse

Method of payment: Cash Credit Card Debit

PRIMARY DENTAL INSURANCE:

NAME OF INSURED _____ DATE OF BIRTH (M/D/Y) _____

EMPLOYER _____

INSURANCE CARRIER OF INSURED _____

GROUP/POLICY NUMBER _____ DIVISION _____

CERTIFICATE/I.D. NUMBER _____

SECONDARY DENTAL INSURANCE:

NAME OF INSURED _____ DATE OF BIRTH (M/D/Y) _____

EMPLOYER _____

INSURANCE CARRIER OF INSURED _____

GROUP/POLICY NUMBER _____ DIVISION _____

CERTIFICATE/I.D. NUMBER _____

DENTAL HISTORY

1. Reason for seeing us: _____

2. When was your last dental visit? _____ Last hygiene appt.? _____ Last set of x-rays? _____
3. What do you use to clean your teeth? Toothbrush Dental floss Sulcabrush Mouthwash Proxabrush
Others? Please list: _____
4. Do your gums bleed spontaneously or when brushing or flossing? Yes No Not Sure
5. Are any of your teeth sensitive to: Hot Cold Sweet Biting
6. Does your jaw pop or click when you open widely? _____ If so, is there any pain on doing so? _____
7. Difficulty in opening or closing? Yes No Not Sure
8. Do you have any of the following oral habits?
 - i) Grind or clench your jaw day or night? Yes No Not Sure If so, frequency? _____
 - ii) Mouth breathing while awake or asleep? Yes No Not Sure
 - iii) Placing foreign objects in your mouth (pencils, nails, pins, fingernails)? Yes No
9. Do you have any concerns about your dental visit? Fear Pain Time Money Embarrassment
10. Please check any of the following that you have had, and circle any that you may be interested in:

<input type="checkbox"/> Orthodontics	<input type="checkbox"/> Repairing chipped teeth	<input type="checkbox"/> Improving gum health	<input type="checkbox"/> Improving your smile
<input type="checkbox"/> Bonding	<input type="checkbox"/> Whitening teeth	<input type="checkbox"/> Improving your bite	<input type="checkbox"/> Sports mouth guard
<input type="checkbox"/> Crowns	<input type="checkbox"/> Replace missing teeth	<input type="checkbox"/> Improving breath odor	<input type="checkbox"/> Nightguard/spint
<input type="checkbox"/> Snoring appliance			
11. i) On a scale of 1 to 10, how would you rate your overall smile/oral health? _____
ii) On a scale of 1 to 10, what would you like your overall smile/oral health to be? _____
iii) What would you like to change to get from where you are to where you want to be? _____

INFORMED CONSENT/GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions regarding my medical/dental history. Should there be any change to my health status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for all fees associated with these services.

Signature: _____
 PATIENT PARENT GUARDIAN (Print name of Guardian)

Reviewed by treating Dentist: _____ **Date:** _____
(month/day/year)
