

Welcome

Astra Dental Patient ID#
5255 Yonge St. Ste. #107
North York, Ontario Medical Alert
M2N 6P4

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. PLEASE PRINT.

Patient Information A parent or guardian will be responsible for decisions on my treatment Yes No

Name: _____
First Initial Last

Address: _____
Street Apt. City Prov. Postal Code

Date of Birth: ____/____/____ Home Tel. (____) _____ Cell Tel. (____) _____
D M Y Email: _____

Emergency Contact: _____ Tel. (____) _____

Family Doctor: _____ Tel. (____) _____

Referring Doctor: _____ Tel. (____) _____

How did you hear about us: _____

Financial Information Method of payment: Cash Cheque Credit Card Insurance Other
Person responsible for financial matters: Self Spouse Parent/Guardian Other

| | |
|-------------------------|--|
| IF DIFFERENT FROM ABOVE | Name: _____ First Initial Last |
| | Address: _____ Street Apt. City Prov. Postal Code |
| | Date of Birth: ____/____/____ Home Tel. (____) _____ Work Tel. (____) _____ D M Y |
| | |

PRIMARY INSURANCE
Ins. Company: _____ Tel. (____) _____
Employer/Policy Holder: _____ Ins. Yr. End: _____
Policy#: _____ Certificate#: _____ ID#: _____
Max Cov. _____ % coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic

SECONDARY INSURANCE
Ins. Company: _____ Tel. (____) _____
Employer/Policy Holder: _____ Ins. Yr. End: _____
Policy#: _____ Certificate#: _____ ID#: _____
Max Cov. _____ % coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic

GENERAL RELEASE

I, the undersigned, 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 consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. 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 or dental diagnostic procedures.

Signature Self Parent/Guardian _____ Print name _____ Date _____

Medical History

(this information will remain confidential)

Date _____

YES · NO

1. Are you presently under the care of a physician? If so, explain. _____
2. Have you ever been hospitalized? Explain. _____
3. Are you taking any drugs or medication at this time?.....
 - A) Drug _____ Reason _____
 - B) Drug _____ Reason _____
 - C) Drug _____ Reason _____
4. Have you ever had any adverse effect to any of the following: Antibiotic- Penicillin , Sulfonamide , Other ; Aspirin ; Barbiturates (sleeping pills) ; Codeine ; Darvon ; Local Anaesthetic ; NONE .
5. Have you ever been warned against using any other medications? Which? _____
6. Have you ever taken prolonged medical or non-medical drugs? Which? _____
7. Do you suffer from any allergies (hay fever, latex etc.)? Which? _____
8. Do you bruise easily or have prolonged bleeding?
9. Do you smoke? How much per day? _____
10. Have you ever fainted, had shortness of breath or chest pains?
11. **WOMEN** Are you pregnant? Yes No Using birth control? Yes No Reached menopause? Yes No
12. Do you have or have you ever had any of the following? Please ✓ appropriate boxes. NONE

| | | | |
|--|--|---|--|
| <input type="checkbox"/> A.I.D.S. | <input type="checkbox"/> Cortisone/steroid | <input type="checkbox"/> High/Low Blood pressure | <input type="checkbox"/> Psychiatric disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> H.I.V. Positive | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Angina pectoris | <input type="checkbox"/> Drug/alcohol dependence | <input type="checkbox"/> Hodgkin's disease | <input type="checkbox"/> Rheumatic/Scarlet fever |
| <input type="checkbox"/> Anorexia nervosa | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hyper (Hypo) Glycemia | <input type="checkbox"/> Sickle Cell disease |
| <input type="checkbox"/> Artificial Heart valve | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Arthritis/rheumatism | <input type="checkbox"/> Glandular disorders | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach/intestinal problems |
| <input type="checkbox"/> Artificial joints (hips, knees) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Head/Neck injuries | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Heart disease/attack | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart pacemaker/surgery | <input type="checkbox"/> Malignant hypothermia | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart rhythm disorder | <input type="checkbox"/> Mental/nervous disorder | <input type="checkbox"/> Covid-19 |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Herpes | <input type="checkbox"/> Organ transplant/implant | <input type="checkbox"/> Other _____ |

13. **CHILDREN** Have you recently had any of the following (approximate date)?

| | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Chicken Pox _____ | <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Strep Throat _____ | <input type="checkbox"/> Tonsillitis _____ | <input type="checkbox"/> NONE |

Dental History

1. What is the reason for today's visit? Emergency Examination Other _____
2. How frequently do you see a dentist? 3-6 months Annually Other _____
3. When was your last dental visit? _____ Last X-Ray? _____
4. How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____
5. Are your teeth sensitive to: Cold Sweets Heat Other _____
6. Do your gums bleed when: Brushing Flossing Never YES NO
7. Do your gums feel swollen or tender?
8. Do you have bad breath or a bad taste in your mouth?.....
9. Do your jaws crack, pop or grate when you open widely?.....
10. Do you grind or clench your teeth?.....
11. Do you have food catch between your teeth?.....
12. Have you ever had local anaesthetic (freezing)?.....

Any complications? Yes No Specify _____
13. Have you ever had any problems with previous dental treatments? Specify _____
14. Have you ever had any of the following: Bridgework Crowns or Caps
 Full or Partial Dentures Orthodontic (braces) Periodontal (Gums) Root Canal
15. Are you satisfied with your teeth? Specify _____

Thank you