Personal Information

Last Name	First Name		Middle
Age Birth Date Day/Month/Year	Married ☐	Single ☐	Child ☐ Other ☐
Address Street or P.O. Box	City	Province	Postal Code
Phone Number Home	Work	Cell	
Email	Occupation	Employer	
Person responsible for bill *(if different than above)*	Address		
Relationship	Daytime Phone Number		
Person to contact in case of an emergency	Daytime Phone Number		

Insurance Information

Please read our office policies regarding insurance and initial box stating you have read and understood these terms.

Single Insurance Coverage

If you have one dental insurance plan, we want you to receive the full benefit of it. As a courtesy, our office team can assist you by submitting your dental claims electronically if your plan accepts. You will be required to pay the full amount on the day of treatment.

Dual Insurance Coverage

If you have two dental insurance plans, we want you to receive the full benefit of it. As a courtesy, our office team can assist you by submitting your dental claims electronically if your plan accepts. You will be required to sign a secondary insurance form at the date of treatment. Remember, however, that you are responsible for the account if the insurance, company for any reason,does not honour their commitment to you and to us. ☐

Primary

Insured Person's Full Name _____ Birth Date Day/Month/Year _____

Relationship to Patient _____ Daytime Phone Number _____

Insurance Company Name _____ Group or Policy Number _____ Certificate or ID Number _____

Employer's Name _____ Employer's Phone Number _____

Secondary

Insured Person's Full Name _____ Birth Date Day/Month/Year _____

Relationship to Patient _____ Daytime Phone Number _____

Insurance Company Name _____ Group or Policy Number _____ Certificate or ID Number _____

Employer's Name _____ Employer's Phone Number _____

Getting to Know You

Why did you select our practice? _____

Whom may we thank for referring you? _____

How do you feel about getting and maintaining a healthy mouth? _____

How do you feel about the appearance of your teeth? _____

If you could change anything about your smile, what would you change? _____

When was your last dental visit? _____

When was the last time you had complete dental radiographs taken? _____

Name & Address of last Dentist _____

Have you ever had any teeth removed? _____

How long have these teeth been missing? _____

Have these teeth been replaced? If so, what year? _____

How? ☐ Bridge ☐ Partial ☐ Denture ☐ Implants

First Avenue Dental Group

Medical History

Physician's Name and Phone Number _____

Pharmacy's Name _____

Saskatchewan Health Card Number _____

Are you having any dental problems at this time? ☐ Yes ☐ No

If yes, please explain _____

Do feel very nervous about having dental treatment? ☐ Yes ☐ No

Do you have any of the following? (Please check all that apply to you)

- ☐ Bleeding gums
- ☐ Broken fillings
- ☐ Chronic bad breath
- ☐ Decayed teeth
- ☐ Food catches between teeth
- ☐ Grinding/Clenching of teeth
- ☐ Injury to teeth or jaw
- ☐ Loose teeth
- ☐ Orthodontic treatment
- ☐ Painful or locking jaw
- ☐ Sensitivity to sweet, hot, cold, biting
- ☐ Sores, growths or swelling in mouth
- ☐ Periodontal treatment

Please check any of the following past or present:

- ☐ AIDS
- ☐ Abnormal bleeding, prolonged healing, bruising easily
- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints_____
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Back problems
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest pain
- ☐ Circulatory Problems
- ☐ Cold sores
- ☐ Concussions
- ☐ Cortisone treatments/steroids
- ☐ Cough, persistent/chronic
- ☐ Diabetes
- ☐ Drug use, recreational
- ☐ Drug addiction/Alcoholism
- ☐ Emphysema
- ☐ Epilepsy/seizures
- ☐ Fainting/Dizziness
- ☐ Glaucoma/eye disorders
- ☐ Headaches, migrane headaches
- ☐ Heart murmur
- ☐ Heart disease (describe) _____
- ☐ Hemophilia
- ☐ Hepatitis A____ B____ C_____
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ HIV positive
- ☐ Hives/Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Mitral valve prolapse
- ☐ Malignancy or tumor/cyst
- ☐ Nervous disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever/rheumatic heart disease
- ☐ Shingles
- ☐ Sinus Trouble
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Congestive heart failure
- ☐ Thyroid disease
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Ulcer/digestive disorders
- ☐ Venereal disease

Do you have any disease, condition or problem not listed? ☐ Yes ☐ No

If yes, please explain _____

WOMEN Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please list all medications you are currently taking as well as over-the-counter- medications, herbal remedies, vitamins

_____

_____

Do you have allergies/reactions to penicillin, latex, aspirin, codeine or any other drugs or medicine? ☐ Yes ☐ No

Have you ever had a bad experience in the dental office? ☐ Yes ☐ No

If yes, please explain _____

Are you presently under a physician's care? ☐ Yes ☐ No

If yes, please explain _____

Please describe any impending operations, recent injuries or other information the dentist should be aware of:

_____

Do you consider yourself to be in good health? ☐ Yes ☐ No

Authorization

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistants as he or she deems fit. I also undersand that previous to the treatment, full explaination of the procedure(s) involved will be given by the doctor and/or team. I agree to pay for all services rendered by this office.

_____ _____ _____

Signature of Responsible Party | Relationship | Date