Stonebridge Dentistry
1 Market Lane, Unit 9
Wasaga Beach, On
L9Z 0B6
reception.stonebridgedentistry@gmail.com
Tel: 705-422-2490 Fax: 705-422-2493

Patient Information (please print)

Title: Mr/Mrs/Ms/Miss/Mast Name: _____
First Initial Last

Address _____
Street Apt City Prov Postal Code

Cell # _____ Home # _____
Home Work

Date of Birth ___/___/___ Email _____
D M Y

Name of Spouse/Parent/Guardian_____
Emergency Contact _____ Phone # _____
Who can we thank for referring you? _____

Financial Information

Do you have dental insurance? Yes/No/More than one

Primary Insurance	**Secondary Insurance**
Subscriber Name _____	Subscriber Name _____
Policy # _____ Id # _____	Policy # _____ Id # _____
Subscriber Date of Birth (D/M/Y) ___/___/___	Subscriber Date of Birth (D/M/Y) ___/___/___
Employer _____ Ins Co _____	Employer _____ Ins Co _____
Relationship to Subscriber _____	Relationship to Subscriber _____

Our office is happy to file claims electronically on your behalf, so that in many cases, we will receive your insurance reimbursement.
As such, payment of your dental visit is expected at the time of service should there be any balances.
Please let your front desk staff know ahead of time, in the event that you are unable to make payment when it is due, so that other options may be discussed with you at that time.

Medical History: (Confidential as per PIPEDA legislation)

Name of family Physician _____ Phone _____ Date of last physical _____

Are you being treated for any medical condition? If so, which?_____
Are you taking any drugs or medications at this time:
Drug: _____ Reason: _____
Are you taking any Herbal or Vitamin Supplements?
Supplement_____ Reason_____
Do you have any drug allergies or adverse effects? (Penicillin, Sulfonamide, Aspirin, Codeine, Local Anesthetic)
_____
Any Latex, Nickel, or General Anesthia Allergies?_____
Do you bruise easily or bleed for a prolonged period of time?_____
Do you smoke? If so how much per day, and how long?_____
Have you ever fainted, had shortness of breath or chest pains?_____

Women: Are you pregnant? YES/NO Nursing? YES/NO Using Birth control? YES/ NO
Have you in the past, or are currently taking and cortisone based medications such as Prednisone?_____

Do you have or have you ever had any of the following medical conditions?

Artificial Joints___ **Anemia___** **Bone Density** **Meds___** **Blood Thinner** **Meds___** **Cancer___** **Radiation___** **Chemotherapy___** **Diabetic___** **Infective** **Endocarditis___** **Hep A/B/C___** **H.I.V Positive___** **Hemophilia___** **Blood Pressure H / L** **Pace Maker___** **Stroke___** **Heart Issues___**	**List Recent Surgeries or hospital visits here:**	Asthma Circulation Problems___ Cortisone/Steroids___ Drug/Alcohol Dependency ___ Eating Disorder___ Epilepsy___ Glaucoma___ Head/Neck Injury___ Herpes___ Hodgkin Disease___ Hyperglycemia___ Jaundice___ Kidney Disease___ Liver Disease___ Lung Disease___	Malignant Hypothermia___ Mental Nervous Disorder___ Mitral Valve Prolapse___ Organ Transplants___ Psychiatric Disorder___ Rheumatic Fever___ Sickle Cell___ Sinus Problem___ Thyroid Problem___ Tuberculosis___ Ulcers___ Other_____ _____

Dental History:
Last Dental Check up and Cleaning?_____ How Frequently do you visit?_____
Do you usually take antibiotics before a procedure?_____
Are you looking for Comprehensive Dental Care, or Emergency Care Only?_____
Do you have a history of Gum Disease?_____Treated?_____Untreated?_____
Have you seen a Periodontist?_____ If so when?_____
Are your teeth sensitive to Sweets?_____ Hot?_____ Cold?_____
Have you been diagnosed with TMJ (jaw joint) problems? _____ If so when?_____ Treated/Untreated?
Does your jaw joints "Click" or "Pop" when you open?_____
Are you aware if you grind or clench your teeth at night? _____
Have you had orthodontic work done (braces)? _____
Do you wear any oral appliances?_____ Removable or Fixed?_____
Have you Professionally Whitened your teeth before? Yes_____ No_____
Are you happy with your smile?_____

GENERAL RELEASE: I, the undersigned, certify that the information contained in the medical and dental history is correct to the best of my knowledge. I consent to the release of medical information from my medical doctor, or other health care providers, if 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 payment for my dental treatment is due at the time of service, unless otherwise arranged for in advance with office management. I understand that I am responsible for my account with this dental office, and that all of my dependents, and I will not allow payments to be in arrears.

_____ _____ _____
Signature Print Name Date