Stone Bridge 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#_____

Date of birth___ /___ /_____ Email_____
D M Y

Name of spouse/ Parents/ Gaurdian_____
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 can 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 Y_____ Anemia N_____ 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:**	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 Checkup 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 TAU (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