Stonebridge Dentistry
1 Market Lane, Unit 9
Wasaga Beach, On
L9Z OB6
reception.stonebridgedentistry@gmail.corn
Tel: 705-422-2490 Fax: 705-422-2493

EatiMUDEsrti (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? _____

Firiancld 14orrnatiori

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

Primary Insurance Subscriber Name	**Secondary Insurance** Subscriber Name
Policy # Id #	Policy # Id #
Subscriber Date of Birth (D/M/Y)_____/___/	Subscriber Date of Birth (D/M/Y)_/_/ 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.	

Medical His-cry: (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?

Astifklal Joints Anemia Bone Density Meds Blood Thinner needs_ Cancer Radiation Chemotherapy Diabetic Infective Endocarditls Hep Ale/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 laundke Kidnev 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

Amid Ffislav

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 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