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***DR. JODI NICKERSON/DR. HANNAH PARK***

***WELCOME PATIENT INFORMATION FORM***

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

FIRST INITIAL LAST

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_

STREET APT.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY PROVINCE POSTAL CODE

**Date of Birth**: \_\_\_/\_\_\_/\_\_\_ (M)\_\_ (F)\_\_ **Home Tel**: (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_**Work Number**: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_

D M Y

**Cell Number**: (\_\_\_)\_\_\_\_\_\_\_\_ **TEXT** (YES) (NO) **EMAIL**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of spouse** (or if child, name of **parents**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact** (if different from above) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Card Number for Child under the age of **15**\_\_\_\_\_\_\_\_\_\_\_\_\_

**If this is your first visit, how did you hear about our office**:

Referred by another person(Whom): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have dental insurance please **present your insurance card** to the front desk prior to being taken in for your appointment along with the following information:

**Policy Holder’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s DOB \_\_/\_\_/\_\_\_**

**Relationship to Policy Holder \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder’s ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dental History**

1. What is the reason for your dental visit today?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. When was your last visit to the dentist (if different office)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Please indicate if any of the following applies:

\_\_Do your gums bleed when you brush or floss?

\_\_Do your teeth experience sensitivity to cold or hot temperatures?

\_\_Are any of your teeth currently causing you pain?

\_\_Do you grind your teeth(either consciously or during sleep)?

\_\_Do you currently have any dental implants, dentures, or partials?

\_\_Have you ever had complications following dental treatment ?

4. If you could change anything about your mouth, teeth or smile, what would it be?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Would you consider yourself to be in fairly good health? Yes \_\_\_ No \_\_\_

In the past year, have there been any changes in your general health? Yes \_\_\_ No \_\_\_

1. Are you currently under the care of a physician due to a specific condition? Yes \_\_\_ No \_\_\_
2. **IT IS NECESSARY** that you provide a list of any medications that you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you been hospitalized due to surgery or illness in the last 5 years? Yes \_\_\_ No \_\_\_
4. Do you have any **allergies** we need to be aware of (drugs, food, latex, etc.)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Do you bruise easily or have prolonged bleeding? \_\_\_\_\_\_\_\_\_
6. Do you suffer from shortness of breath or chest pain? \_\_\_\_\_\_ Are you a smoker? \_\_\_\_\_\_\_\_
7. Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Do you have or, have you ever had any of the following:

\_\_HIV +(AIDS) \_\_Blood disorders \_\_Arthritis

\_\_Cancer \_\_Diabetes \_\_Nervous Disorder

\_\_Hepatitis \_\_High/Low blood pressure \_\_Fainting or seizures (ie:epilepsy)

\_\_Stomach problems \_\_Asthma \_\_Malignant hypothermia

\_\_Artificial joints \_\_Sinus problems \_\_Kidney Disease

\_\_Rheumatic fever \_\_Head/neck injuries \_\_Thyroid disease

\_\_Heart disease(rhythm disorder, lesions, pacemaker, heart attack, artificial valve,stroke,

mitral valve prolapse, etc.)

\_\_\_Other (Please explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The Personal Health Information Act(PHIA) became law in June 2013. PHIA protects your right to privacy but also recognizes the need for health care providers to use or share your personal health information in order to provide you with the best health care possible. Examples of personal health information include: your name, date of birth, address, health card number and medical information related to your physical health.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I consent to the performing of dental procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am responsible to know the details of my insurance coverage and that I am financially responsible for any outstanding balance for services provided that are not fully covered by my insurance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Signature of patient, parent, or guardian Print Name Date