Guelph Village Dental

Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Email: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____

Address: _____
Street Apartment #

_____
City Province Postal Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____ _____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
OTHER:
☐ _____
Medication:
☐ _____

☐ Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:_____

☐ Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:_____

☐ Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:_____

☐ Name of Physician: _____ Phone:_____

☐ Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Friend, Family ☐ Location

☐ Walk by ☐ Speedvale Office ☐ Newspaper ☐ Website ☐ Work ☐ Invisalign_____

Name of person or office referring you to our practice:_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Consent for Services

Welcome to our Dental Office.

As a condition of your treatment by this office, we expect payment on the day of service.

Patients who carry dental insurance understand that all dental services completed that day are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms and with your permission will send your insurance claim electronically to your insurance company. You will receive payment from your insurance company within 5-7 days.

Our office expects and would appreciate 48 hours notice for any appointment changes.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party