BLOOR DENTAL CLINIC

464 Bloor Street West, Toronto ON M5S 1X8
phone |416.535.2111

Welcome to Bloor Dental Clinic. We look forward to getting to know you, your family and friends and caring for your dental health, with the goals of high quality and gentle dentistry in mind. We treat all of our patients in the same manner as we would treat our families and ourselves. We will present you with your diagnosis and treatment options, honestly and openly, to help you make confident choices. We are proud of our safe and friendly environment and dependable services.

About the Patient

Mr. Mrs. Miss Ms. Dr.

Last name: _____ First name: _____ Preferred name: _____

Birthday: M _____D_____Y_____ Marital status _____ Email_____

Home address: _____ City: _____ Province: _____ Postal code: _____ _____

Home phone #: (_____)_____-_____ Work phone #: (_____)_____-_____ ext: _____ Other: (_____)_____-_____

Where and when are the best times to reach you? _____ Occupation: _____

Person responsible for account: _____ Relationship: _____

Emergency contact: _____ Relationship: _____ Phone #: (____) _____-_____

Whom may we thank for referring you to our practice? _____

Other family members seen by us: _____

Patient is a child ___ an adult under guardianship ___ Who is with the patient today? _____ Relation _____

Mother's name: _____ Work #: (_____) _____-_____

Father's name: _____ Work #: (_____) _____-_____

Legal guardian: _____ Work #: (_____) _____-_____

Do you have dental insurance? ____ Yes ____ No If so, please give your insurance information to the front desk.

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? ____Y ____N Please explain: _____

Do you brush twice a day? ___Y ___N Do you floss daily? ___Y ___N Do you use mouthwash? ___Y ___N Other _____

Do you have any of the following? Bleeding gums __Y __N Food caught in your teeth __Y __N Sensitive teeth __Y __N Loose teeth __Y __N

How would you rate your previous dental experience? 1 Being relaxed 5 Extremely nervous _____

Are you happy with the appearance of your teeth? ___Y ___N If no, what would you change? _____

Previous dentist: _____ Last visit date: _____/_____ Reasons: _____

Medical History

Physician's name: _____ Address: _____ Phone #: (_____) _____-_____

Specialist's name: _____ Address: _____ Phone #: (_____) _____-_____

Specialist's name: _____ Address: _____ Phone #: (_____) _____-_____

Have you been under medical care within the past two years? ___Y ___N Reason: _____

When was your last physical exam? _____ Result: _____

When was your last visit to a physician? _____ Reason: _____

Please turn over

Medical History Cont.

Do you or have you ever experienced the following? Please indicate Y - yes N - no or (?) if not sure for each condition

__ Abnormal bleeding	__ Head/neck injuries	__ Alcohol / drug abuse	__ Tuberculosis (TB)	__ High / low blood pressure
__ Abnormal bruising	__ Headaches/migraines	__ Steroid therapy	__ Persistent cough	__ High cholesterol
__ Blood transfusion	__ Sinus problems	__ Cancer	__ Emphysema	__ Congenital heart defect
__ Blood disorder	__ Glaucoma/Cataract	__ Radiation treatment	__ Asthma	__ Heart murmur
__ Hemophilia	__ Artificial joints	__ Chemotherapy	__ Lung problem	__ Heart surgery
__ Liver disease	__ Seizures/Epilepsy	__ Venereal disease	__ Shortness of breath	__ Heart attack/Angina
__ Jaundice	__ Arthritis/Rheumatism	__ Herpes	__ Sleep apnea	__ Pacemaker
__ Hepatitis A B C	__ Lupus	__ Immune problems	__ Thyroid problems	__ Swollen ankles, feet, or hands
__ Sickle cell anemia	__ Organ transplant	__ HIV/ AIDS	__ Kidney problems	__ Rheumatic fever
__ Anemia	__ Colitis/Ulcers	__ Psychological problems	__ Diabetes	__ Mitral valve prolapse
__ Prostate problems	__ Ever hospitalized	__ Malignant hyperthermia	__ Stroke	__ Artificial valves

__ Pre-medication with antibiotics for dental treatment BP: _____HR: _____

Others _____

Please explain: _____

Women only: Are you taking birth control pills? ____Y ____N Are you pregnant? ____Y____N Number of months? _____

Are you taking any prescription / over the counter drugs or herbal supplements? ____Y ____N Please list them: _____

Please list them: _____

Please circle your allergy (ies): Aspirin Barbiturates Codeine Anaesthesia Erythromycin Penicillin Clindamycin

Sulfa drugs Tetracycline Injections Jewelry/metals Latex Others _____

Consent and Policies

- I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform the office of any changes in my medical status.
- I acknowledge that my dental benefits are my responsibility. I understand that I am responsible for payment of services rendered for my dependents and myself. Payment is due on the day of service rendered unless otherwise financially arranged. A fee of $45.00 is charged per NSF cheque.
- My appointments are considered confirmed when scheduled. Bloor Dental Clinic requires a notice of 2 business days for any changes to my reserved appointment. A fee of $50.00 per appointment is charged for no-show, or short noticed cancellation.
- I have reviewed the information that explains how Bloor Dental Clinic will use my personal information, and the steps Bloor Dental Clinic will take to protect my information. I agree that Bloor Dental Clinic can collect, use and disclose personal information about my dependents & myself as set out in the information about the office privacy policies. I can ask to see these policies at any time.
- I give consent to the dental staff to provide the necessary diagnosis and treatment, and authorize the release of my information and my dependents' information to my dental insurance company/plan administrator for Electronic Dental Insurance (EDI) submission.

We are pleased to answer any questions you may have or receive your feedback. Thank you for joining our dental family at Bloor Dental Clinic

Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____