WESTGAGE DENTAL

Dr. Anil Shetty DDS

Welcome to Our Dental Office

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private, and is protected by doctor-patient confidentiality. Please fill in the entire form.

PERSONAL INFORMATION

Dr. Mr. Mrs. Miss Ms Name: _____

Name you would like to be called: _____

SIN #: _____ Date of Birth (DD/MM/YYYY): _____

Home Tel: _____ Office Tel: _____ Ext: _____

Address: _____ Apt: _____

City: _____ Postal Code: _____

Occupation: _____ Employer: _____

Email: _____ Physician: _____

Previous Dentist: _____ Physician's Phone No: _____

Why have you decided to change dental offices? _____

_____

How did you hear about us? _____

INSURANCE INFORMATION 1

Name of Insured if different from above: _____

Insurance Company: _____ Birthdate of Insured (DD/MM/YYYY): _____

Division if applicable: _____ Policy/Group: _____

Employer: _____ Certificate ID #: _____

Do you have secondary Insurance? _____

INSURANCE INFORMATION 2

Name of Insured if different from above: _____

Insurance Company: _____ Birthdate of Insured (DD/MM/YYYY): _____

Division if applicable: _____ Policy/Group: _____

Employer: _____ Certificate ID #: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Tel: _____

MEDICAL HISTORY

	YES	NO
Are you being treated for any medical condition at the present or have you been treated within the last year?	☐	☐
If yes, specify: _____		
When was your last medical check-up? _____		
Has there been any change in your general health in the past year?	☐	☐
Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below:	☐	☐

Drug: _____ Reason: _____

Drug: _____ Reason: _____

Drug: _____ Reason: _____

SEE REVERSE

	YES	NO
Do you have any allergies? ❑ Latex ❑ Other: _____	❑	❑
Have you had an unusual reaction to any drugs or medicines?	❑	❑
❑ Penicillin ❑ Sulfonamide ❑ Aspirin ❑ Codeine ❑ Local Anesthetic ❑ Other: _____		
Have you ever taken cortisone or steroid medication?	❑	❑
Do you have any sinus problems?	❑	❑
Do you have or have you ever had any heart problems?	❑	❑
Do you have a pacemaker?	❑	❑
Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?	❑	❑
Do you or have you ever had jaundice, hepatitis or liver disease?	❑	❑
Do you have a bleeding problem or bruise easily?	❑	❑
Do you have any conditions that could affect your immune system eg. AIDS, HIV infection, Leukemia etc?	❑	❑
Do you smoke? If yes, how much? _____	❑	❑
Have you ever been hospitalized for any serious illnesses or operations?	❑	❑
Do you have any prosthetic or artificial joints?	❑	❑

Do you have or have you ever had any of the following?

❑ Chest Pain/Angina	❑ Heart Attack	❑ High Blood Pressure	❑ Stroke	❑ Tuberculosis	❑ Arthritis
❑ Emphysema	❑ Epilepsy	❑ Thyroid Disease	❑ Diabetes	❑ Asthma	❑ Stomach Ulcers
❑ Kidney Disease	❑ Cancer	❑ Chemotherapy/Radiation	❑ Psychiatric Disorder	❑ Drug/Alcohol Dependency	

For females: Are you pregnant or breast feeding?	❑	❑
Any other conditions or problems of which the dentist should be aware of?	❑	❑

If yes, please list: _____

_____

DENTAL HISTORY

	YES	NO
When was your last dental visit? _____		
When did you last have dental x-rays? _____		
How often do you brush your teeth? _____		
How often do you floss your teeth? _____		
Have you been seeing a dentist regularly?	❑	❑
Do any of your teeth ache?	❑	❑
Have you ever been advised to take antibiotics before dental appointments?	❑	❑
Do your gums bleed when you brush?	❑	❑
Do you have any pain when you chew?	❑	❑
Do you feel that you have bad breath?	❑	❑
Have you ever been in a motor vehicle accident or experienced any blows to your jaw?	❑	❑
Have you ever had a dental implant surgery?	❑	❑
If yes, who performed the surgery and when was it done? _____		
Are you being followed-up by a dental specialist?	❑	❑
Please list anything else not mentioned above regarding your past dental history: _____		

_____

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general and local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

_____	_____	_____	_____
Signature of patient	DD / MM / YYYY	Reviewed by dentist	DD / MM / YYYY