

# Welcome to Our Office

We look forward to becoming partners in your dental health care. Our approach to dentistry is prevention oriented and is a team effort involving you and our staff. Together we will address any current dental concerns and endeavour to prevent future dental problems.

## Personal Information

Title \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Nickname: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Sex: M  F  Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(DD/MM/YY)

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

Unit # \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Business Phone # \_\_\_\_\_ Ext: \_\_\_\_\_

Cell #: \_\_\_\_\_ Email address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Former Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Who may we thank for inviting you to our practice? \_\_\_\_\_

Family member(s) in our practice: \_\_\_\_\_

## **Financial Information / Person responsible for financial matters:**

\_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Name Last Name (DD/MM/YY)

Home Phone #: \_\_\_\_\_ Business Phone # \_\_\_\_\_ Ext: \_\_\_\_\_

## **PRIMARY INSURANCE**

Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Name Last Name (DD/MM/YY)

Insurance Company: \_\_\_\_\_ Employer/ Policy Holder: \_\_\_\_\_

Policy or group #: \_\_\_\_\_ Certificate or ID #: \_\_\_\_\_ Division: \_\_\_\_\_

## **SECONDARY INSURANCE**

Subscriber: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Name Last Name (DD/MM/YY)

Ins. Company: \_\_\_\_\_ Employer: \_\_\_\_\_ Policy #: \_\_\_\_\_ ID#: \_\_\_\_\_

I consent to my physician being contacted, if necessary, as this information may be required for my dental care. I also assume responsibility for any fees associated with the dental services provided by Dr. Sungaila / Dr. Zweig and staff.

I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to Dr. Sungaila / Dr. Zweig. This authorization shall continue in effect until the undersigned revokes the same.

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Sungaila / Dr. Zweig and authorize payment directly to her.

Signature of patient, parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

If parent/guardian, please print name (First, Last): \_\_\_\_\_

# MEDICAL HISTORY

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. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

EMERGENCY CONTACT: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

1. Are you currently being treated for any medical condition or have you been treated within the past year?  YES  NO  
If so, why? \_\_\_\_\_

2. When was your last medical checkup? \_\_\_\_\_

3. Has there been any change in your general health in the past year? (i.e. unexplained weight, appetite or frequency of urination changes)  
 YES  NO If so, please explain. \_\_\_\_\_

4. Have you ever been hospitalized for any illnesses or operations?  YES  NO  
If so, please explain. \_\_\_\_\_

5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?  YES  NO  
If so, please list. \_\_\_\_\_

6. Are you on any special diet? (e.g. salt restricted diet). If so, why? \_\_\_\_\_  YES  NO

7. Have you had any antibiotics in the last 3 months? If so, why? \_\_\_\_\_  YES  NO

8. Do you bruise easily or have bleeding problem or bleeding disorder? \_\_\_\_\_  YES  NO

9. Have you ever fainted, had shortness of breath or chest pains? If so, what were the circumstances? \_\_\_\_\_  YES  NO

10. Do you suffer from canker sores or cold sores? \_\_\_\_\_  YES  NO

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? \_\_\_\_\_  YES  NO

12. Have you ever had hepatitis, jaundice or liver disease? \_\_\_\_\_  YES  NO

13. Do you have any organ transplants or joint replacements? If so, since when? \_\_\_\_\_  YES  NO

14. Do you have any allergies? Including: Medications, foods, latex, environmental, other?  YES  NO  
If so, please list: \_\_\_\_\_

15. Have you ever had an adverse reaction to any of the following. If so, explain: \_\_\_\_\_  YES  NO  
**Aspirin      Penicillin      Codeine      Latex      Dental Freezing      Other:** \_\_\_\_\_

16. Have you ever had an adverse reaction to metal or metal jewelry? If so, please explain \_\_\_\_\_  YES  NO

17. Have you been told by your medical doctor that you need to take antibiotics before dental treatments?  YES  NO

18. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)  
 YES  NO If so, please explain: \_\_\_\_\_

19. Do you have or have you ever had asthma? If so, since when? \_\_\_\_\_  YES  NO

20. Do you smoke or chew tobacco products? If so, how many / how often? \_\_\_\_\_  YES  NO

## MEDICAL HISTORY

21. Do you have or have you ever had any of the following? Please circle

Organ Transplant	Joint / Hip replacement	Pacemaker	Head/ neck injuries
High Blood Pressure	Congenital Heart Disease	Stroke/ Heart Attack	Mitral valve prolapse
Anemia/ Blood Disorders	Heart Valve Replacement	Heart Murmur	Chest pain /Angina
Ulcers/Stomach Disorders	Emphysema / Lung disease	Kidney Disease	Thyroid disease
Gall bladder disorders	Liver Disease / Hepatitis A/B/C	Osteoporosis	Arthritis / Rheumatism
Sinus or Nasal problems	Diabetes, Hyper / Hypoglycemia	Steroid therapy	Tuberculosis
Mental/ Nervous Disorders	Down Syndrome / Cerebral Palsy	Epilepsy / seizures	ADD / autism
Drug/Alcohol dependency	Sexually Transmitted Disease	H.I.V. / A.I.D.S.	Eczema / Psoriasis
Deafness or Blindness	Multiple Sclerosis	Cancer	Rheumatic fever

• Please list any conditions or diseases not listed above that you have or have had: \_\_\_\_\_

**For women only:**

Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? \_\_\_\_\_  YES  NO

Are you taking birth control pills? \_\_\_\_\_  YES  NO

Are you menopausal or post-menopausal? If so, are you on hormone replacement therapy? \_\_\_\_\_  YES  NO

## DENTAL HISTORY

1. What has brought you to our office today? \_\_\_\_\_

2. How often do you usually visit a dental office? \_\_\_\_\_ When was your last visit? \_\_\_\_\_

3. What was done at last visit? \_\_\_\_\_ Were X-rays taken?  YES  NO

4. Have you ever had a negative dental experience? If yes, please explain: \_\_\_\_\_  YES  NO

5. Are you generally tense during dental treatment?  YES  NO

6. Have you ever suffered an accident involving your face or jaws? If so, when? \_\_\_\_\_  YES  NO

7. Do you have any of the following? Please circle.      **Discomfort**      **Pain**      **Sensitivity**      **Infection / swelling**  
 If so, where? \_\_\_\_\_ Since when \_\_\_\_\_

8. Do you have any of the following? Please circle.      **Broken fillings or teeth**  
**Bad breath**      **Food collection between teeth**      **Periodontal treatment**      **Bleeding or irritated gums**  
**Loose teeth**      **Sores or growth in mouth**      **Clicking or popping jaws**      **Grinding or clenching teeth**

9. How many times a day do you brush? \_\_\_\_\_ How many times a day do you use floss? \_\_\_\_\_

10. If there is anything you would change about your smile, what would it be? \_\_\_\_\_

To the best of my knowledge, the above information is correct and I have not omitted any pertinent information. I hereby consent to performing whatever is deemed necessary for proper diagnosis and treatment. These may include the use of x-ray, local anesthesia, and other medication. I understand that treatment options will be discussed and I have the right to be provided answers to questions which may arise during the course of treatment. Further, I understand the risk, benefits, and possible complications of dental treatment. I also understand that complications could change treatment.

PATIENT/PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ NAME (Please print): \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM/DD/YY

DENTIST SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM/DD/YY

## **Waterside Dental**

Dr. G. Sungaila  
1252 Hurontario Street  
Mississauga, ON L5G 3H3  
(905) 271 7171  
[info@watersidedental.ca](mailto:info@watersidedental.ca)

## PAYMENT AND CANCELLATION AGREEMENT

### PAYMENT AGREEMENT

I understand that payment or services received at Waterside Dental clinic is my responsibility. If my claim is to be submitted to an outside agency for payment, and for any reason the third party payer such as personal insurance or employer, denies the claim and/or refuses to pay all or any of the full amount billed, I am responsible for paying the amount outstanding or any co pay owed.

Patient signature \_\_\_\_\_

### CANCELLATION AGREEMENT

I understand that I am responsible for providing 48 hours notice for appointment cancellations. (If you do not provide adequate notice to cancel your appointment, we lose two patients-you and the person who could have been treated in that time slot.)

I acknowledge that if I do not provide 48 hours notice, I may be charged a cancellation fee. I understand that third party funders may not pay for cancellation charges I may incur, and that I will be personally responsible for paying such cancellation charges.

Patient signature \_\_\_\_\_

Date \_\_\_\_\_