# 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 : ____/____/____ (DD/MM/YY)
First Name Last Name

Home Phone #: _____ Business Phone # _____ Ext: _____

**PRIMARY INSURANCE**

Subscriber: _____ _____ Date of Birth : ____/____/_____ (DD/MM/YY)
First Name Last Name

Insurance Company: _____ Employer/ Policy Holder: _____

Policy or group #: _____ Certificate or ID #: _____ Division: _____

**SECONDARY INSURANCE**

Subscriber: _____ _____ Date of Birth : ____/____/_____ (DD/MM/YY)
First Name Last Name

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**
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Mississauga, ON L5G 3H3
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# 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 _____