WELCOME TO CARLETON SQUARE DENTAL

Please answer the following questions to help us to better care for your dental needs. All information will be confidential and is for our records only.

DR MR MRS MS MISS MSTR Last Name_____ First Name_____
Birth date (M/D/YR)_____ Male( ) Female( )
Address_____City_____ POSTAL CODE_____
Phone HM_____WK_____CELL_____
EMAIL_____ Who may we thank for referring you?_____

MEDICAL HISTORY

Name of physician_____ phone_____
Women only – are you pregnant? **Y N** due date_____
Have you been hospitalized in the past 5 years? **Y N** If yes, for what reason? _____

Have you ever had an unusual reaction/ allergy to any medication? (i.e.: penicillin, codeine, local anesthetic, sulpha, NSAIDs, etc)

_____

Please circle all of the conditions that you have now or have had in the past

Asthma/Hay Fever	High/Low Blood Pressure	Epilepsy/Seizure Disorder	Stomach Disorders	Thyroid Disease
Cancer	Heart Murmur	Substance Abuse	Psychiatric Disorders	Blood Disorders/Anaemia
Diabetes	Heart Attack/Surgery	Arthritis/Rheumatism	Lung Disease/Tuberculosis	
Sinus Trouble	Artificial Joints/Heart Valves/Pacemaker		Hepatitis/Jaundice/Liver Disease	
AIDS/HIV+	Frequent Alcohol Consumption	STD's	Frequent/Severe Headaches	

If you have any disease, condition or problem not mentioned about, please describe_____
Please list medications you are currently taking (prescription and/or non-prescription)_____
Do you smoke?(tobacco, marijuana ,other) How many per day and for how long?_____

Dental History

Name of previous dentist_____ Date of last dental visit_____ Purpose of visit_____
Have you had regular dental visits in the past? **Y N** Are you currently having any dental pain? **Y N**
Have you been treated for periodontal (gum) disease in the past? **Y N** Is there a family history of periodontal (gum) disease? **Y N**
Do your gums bleed when you brush or floss? **Y N** Are you aware of any sores or lumps in your mouth? **Y N**
Do you get popping or clicking sounds from your jaw? **Y N** Are you aware of clenching or grinding your teeth? **Y N**
Have you had surgery/radiation treatment to your head/neck? **Y N** Have you ever had orthodontic treatment (braces)? **Y N**
Have you ever had a bad reaction or abnormal bleeding with past dental procedures? **Y N**
How often do you brush your teeth? _____How often do you floss? _____
Is there anything about the appearance of your teeth that concerns you? _____
When receiving dental treatment would you consider yourself: Relaxed___ Mildly apprehensive___ Nervous but under control___ Extremely nervous____
What concerns you most about receiving dental treatment?_____
What, if any, is/are your current dental issue(s)?_____

Consent to Treatment:

1. I certify that the above information is correct to the best of my knowledge.
2. I authorize the doctor upon consultation and direct consent from the patient/parent/guardian to perform diagnostic procedures, treatment, and medication in the connection with the patient's dental needs.
3. I understand that responsibility for payment of dental services, including insurance or otherwise, is due and payable at the time services are rendered and despite any dental insurance. I am ultimately responsible for any fees withheld by the insurance company.

_____ _____ Patient ( ) Parent ( ) Guardian ( )
. Date Signature

OFFICE POLICY REGARDING DENTAL PLANS

As a courtesy and convenience to you, our patient, Carleton Square Dental accepts dental plans upon confirmation of your coverage and the information your insurance company discloses. Based on this information, we are able to provide you with ***estimates*** of treatment required to the best of our knowledge.

Your dental policy is a contract between you, your employer and your insurance company. Should your coverage terminate or change in any way, we can only be notified of this by YOU, the patient. If treatment is not paid by your dental plan, it is the sole responsibility of you, the patient, to cover all costs.

We bill all treatment done on the day the service is rendered. If we have not received payment from your insurance company within 60 days of services rendered, then this claim becomes your responsibility. Any portion of any claim submitted to your insurance company that is not paid in a timely manner will become your responsibility.

Payment for services rendered is expected in full upon us notifying you by phone, email or mail. Should payment not be made, Carleton Square Dental may exercise the right to transfer your account to a Debt Collection Agency.

I have read and understand the above and agree with the terms and conditions.

NAME: _____ *(please print)*

SIGNATURE: _____ *DATE:* _____

Patient ( ) Parent ( ) Guardian ( )