Fitzgerald
DENTISTRY

WE ARE PLEASED TO WELCOME YOU TO OUR PRACTICE. PLEASE TAKE A FEW MINUTES TO FILL OUT THIS FORM AS COMPLETELY AS YOU CAN. IF YOU HAVE QUESTIONS WE'LL BE GLAD TO HELP YOU. WE LOOK FORWARD TO WORKING WITH YOU IN MAINTAINING YOUR DENTAL HEALTH.

PERSONAL INFORMATION

☐MR ☐MRS ☐MS ☐MISS ☐DR

Name _____ _____
Last Name First Name Preferred Name, if different from first

Date of Birth _____DD/MM/YYYY_____ Age _____ Employer _____

Address _____ _____ _____ _____ _____ _____
Unit Number Street City Province Postal Code

Preferred Phone _____ Alternate Phone _____
☐ home ☐work ☐cell ☐home ☐ work ☐cell

Email_____

Emergency Contact _____ Phone _____

Whom may we thank for referring you? _____

Do other members of your family see us? _____

INSURANCE INFORMATION

Do you have dental insurance ☐ Yes ☐No? If yes, please complete the following information so we may prepare claim forms or electronically submit claim forms for you.

Name of Subscriber _____ Relationship to Subscriber _____

Name of Insurance Company _____ Plan # _____

ID # _____ Subscriber Date of Birth _____

For secondary insurance, please complete the following:

Name of Subscriber _____ Relationship to Subscriber _____

Name of Insurance Company _____ Plan # _____

ID # _____ Subscriber Date of Birth _____

PLEASE CONTINUE ON REVERSE SIDE. THANK YOU

DENTAL INFORMATION

What is the name of your previous dentist?_____ When was your last dental checkup?_____

Did your previous dentist take any x-rays? □ Y □ N If so, when? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Do you presently have any of the following? Please check ☑ Yes or ☑ No

☐Y ☐N Pain or discomfort ☐Y ☐N Missing teeth ☐Y ☐N Sensitivity (hot, cold, sweets or biting)
☐Y ☐N Broken teeth ☐Y ☐N Bad breath ☐Y ☐N Jaw pain or grinding
☐Y ☐N Lost fillings ☐Y ☐N Sore or bleeding gums ☐Y ☐N Appearance (shape, size, colour of teeth)

Details _____

Have you ever had any of the following? Please check ☑Yes or ☑No

☐Y ☐N Orthodontic treatment ☐Y ☐N Extractions ☐Y ☐N Gum treatment/surgery ☐Y ☐N Dental Implants
☐Y ☐N Root Canal treatment ☐Y ☐N Dental Injury ☐Y ☐N Jaw Pain/Grinding ☐Y ☐N Adverse reaction

Office Use _____

MEDICAL INFORMATION

Physician's Name _____ Phone _____ When was your last check up? _____

Are you currently undergoing medical treatment? ☐Y ☐N If so, please explain _____

Do you have a latex or drug allergy? ☐Y ☐N If so, please explain_____

Are you taking any medications? ☐Y ☐N If so, please list _____

Have you ever had any of the following? Please check ☑ Yes or ☑No

☐Y ☐N AIDS/HIV positive
☐Y ☐N Anaphylaxis
☐Y ☐N Anemia
☐Y ☐N Arthritis
☐Y ☐N Artificial heart valves
☐Y ☐N Artificial joints
☐Y ☐N Asthma
☐Y ☐N Allergy
☐Y ☐N Anxiety
☐Y ☐N Blood disease
☐Y ☐N Cancer
☐Y ☐N Chemical dependency
☐Y ☐N Chemotherapy
☐Y ☐N Diabetes
☐Y ☐N Eating disorder
☐Y ☐N Epilepsy or seizures
☐Y ☐N Fainting
☐Y ☐N Headaches
☐Y ☐N Heart attack or chest pain
☐Y ☐N Heart murmur
☐Y ☐N Hemophilia or bleeding disorder
☐Y ☐N Hepatitis A B or C
☐Y ☐N High blood pressure
☐Y ☐N Kidney disease or malfunction
☐Y ☐N Leukemia
☐Y ☐N Liver disease or jaundice
☐Y ☐N Osteoporosis medication
☐Y ☐N Pacemaker or heart surgery
☐Y ☐N Pregnant or breastfeeding
☐Y ☐N Psychiatric Care
☐Y ☐N Radiation treatment
☐Y ☐N Respiratory disease
☐Y ☐N Rheumatic fever
☐Y ☐N Steroid therapy
☐Y ☐N Surgical implant
☐Y ☐N Thyroid disease
☐Y ☐N Stroke
☐Y ☐N Tobacco habit
☐Y ☐N Tuberculosis
☐Y ☐N Ulcers in stomach or colitis
☐Y ☐N Other: _____
_____

Office Use _____

AUTHORIZATION

☐ BY CHECKING THIS BOX, I CONFIRM THAT I HAVE REVIEWED THE INFORMATION ON THIS QUESTIONNAIRE, AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE. IF THERE IS ANY CHANGE IN MY MEDICAL STATUS, I WILL INFORM THE DENTIST. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES RELATED TO SERVICES PROVIDED AND PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE.

PATIENT'S AUTHORIZATION _____ DATE _____

DENTIST'S AUTHORIZATION _____ DATE _____