HARBORD DENTISTRY

Patient Information			Insurance Information
First Name	Last Name		Insurance Company Name
Address			Certificate Number (If applicable)
City	Province	Postal Code	Group Number (If applicable)
Home Phone	Work Phone	Cell Phone	Insurance Holder Name (if different than the patient, e.g. Spouse)
Email			Insurance Holder Date of Birth
Preferred Method of Contact ☒Phone ☒Email		Language Spoken:	Insurance Holder Address (Include Postal Code)
Birth Date	Marital Status ☒S ☒M ☒CLP ☒Div ☒Wid		Insurance Holder Employer
☒Male ☒Female ☒Other ☒Rather Not to Specify			Insurance Holder Employer Address
This form is being completed by: ☒Patient ☒Parent ☒Legal Guardian ☒Other (Please explain)			If you have another insurance plan, please provide the same information as above:
How did you find out about our office?			
Emergency Contact Name	Emergency Contact Phone		
Patients under the age of 18 cannot be treated unless accompanied by a parent or legal guardian.			**If you don't know your certificate and group number, you can email us an image of your insurance card.**

Person Financially Responsible for Account		
Name	Relationship	Date of Birth

Authorization to Release Information	
I hereby certify that I have or will review the Plan Of Treatment and the Fee to be charged. I authorize the release of any information relating to these services. I understand that the dentist will estimate my co-payment (if any) and bill my insurance company (if applicable). I understand that I am financially responsible for this account.	
Patient's Signature (Parent or Legal Guardian):	Date:

Authorization to Pay Benefits to Dentist	
I hereby authorize payment directly to the dentist of the benefits otherwise payable to me for services rendered. This authorization may be kept on file to be used for this dentist.	
Patient's Signature:	Date:

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Medical History

General Health Condition: ☒Excellent ☒Good ☒Fair ☒Poor

Are you under the care of a medical doctor at present? ☒Yes ☒No	If yes, for what?
Medical Doctor's Name (Clinic or Hospital Name), address, and phone number:	
Are you taking medication now? ☒Yes ☒No	If yes, what medication?
Are you allergic or have had any reaction to any medication? ☒Yes ☒No	If yes, which medication?

Have you had a reaction to penicillin, erythromycin, codeine, aspirin, or local anesthetics? ☒Yes ☒No

Indicate which of the following you have had or have now (check any boxes that apply)

☒ Heart disease/attack	☒ Anemia	☒ A.I.D.S.
☒ Heart Surgery	☒ Ulcers	☒ H.I.V. Positive
☒ Congenital Heart Disease	☒ Emphysema	☒ Venereal Disease
☒ Heart Murmur	☒ Diabetes	☒ Cold Sores
☒ High Blood Pressure	☒ Thyroid Problem	☒ Blood Transfusion
☒ Rheumatic Fever	☒ Glaucoma	☒ Hemophilia
☒ Heart Pacemaker	☒ Tuberculosis	☒ Herpes
☒ Artificial Heart Valve	☒ Cough	☒ Epilepsy or Seizures
☒ Artificial Joint	☒ Asthma	☒ Nervous Condition
☒ Mitral Valve Prolapse	☒ Hay Fever	☒ Liver Disease
☒ Hip Replacement	☒ Sinus Trouble	☒ Yellow Jaundice
☒ Dialysis Treatment	☒ Cortisone Medication	☒ Fainting, Dizzy Spells
☒ Organ Transplant	☒ Chemotherapy	☒ Psychiatric Treatment
☒ Bacterial Endocarditis	☒ Tumors	☒ Sickle Cell Disease
☒ Stroke	☒ Latex Sensitivity	☒ Drug Addiction
☒ Angina (Chest Pain)	☒ Hepatitis A (Infectious)	☒ Hepatitis
☒ Scarlet Fever	☒ Hepatitis B (Serum)	☒ Do you Smoke

Do you have any other disease, medical condition or problem not listed? ☒Yes ☒No

If yes, please list here:

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For Women Only		
Are you pregnant? ☒Yes ☒No	Are you breastfeeding? ☒Yes ☒No	Are you taking birth control pills? ☒Yes ☒No
If Yes, when are you due?	**Antibiotics may decrease effectiveness or birth control pills or Norplant, check with your doctor.**	
Patient's Signature		
To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the dentist at the next visit without fail.		
Patient's Signature (Parent or Legal Guardian if minor)	**Date:**	

Dental History

What is the reason for your visit today?		
Date of last Dental Visit	Date of last full mouth X-ray	Date of last teeth cleaning
Name of your last dentist	Are you currently undergoing treatment with another dentist? ☒Yes ☒No	If yes, for what?
Do you see dentist regularly for examination and cleaning? ☒Yes ☒No		Do you use floss? ☒Yes ☒No
Are you having pain from your mouth now? ☒Yes ☒No	Do your gum bleed? ☒Yes ☒No	Have you been advised you have gum disease? ☒Yes ☒No

Indicate which of the following you have had or have now (check any boxes that apply)	
☒ Clicking, Popping of jaw	☒ Pain in joint, ear, side of face
☒ Difficulty in opening or closing your mouth	☒ A bite splint or mouth guard
☒ Injury to mouth or head	☒ Bite adjusted by dentist
☒ Clenching or grinding teeth	☒ Bad odors or tastes from mouth
In the case of injury, please describe	
Please explain if there is anything you want us to know regarding your dental treatment.	
Patient's Signature	
Some dental procedures take more time than others. If you are tired and want a break, or if your jaw gets tired from being open, please notify the dentist or hygienist so you can rest, making your dental visit a more pleasant experience.	
Patient's Signature (Parent or Legal Guardian if minor)	**Date:**