WELCOME TO OUR OFFICE

PATIENT AND OFFICE INFORMATION **ALL INFORMATION IS CONFIDENTIAL**

Name: _____ Address: _____ Postal Code: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____ Family Physician: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

Dental Insurance: Yes/No Insurance Co. Name: _____ Policy # _____ Certificate # _____

Name of Subscriber: _____

MEDICAL HISTORY

Have you ever had a serious illness requiring hospitalization or extensive medical care? _____

Specify: _____

_____

Are you presently under the care of a physician? If so, why? _____

Are you currently taking any prescription or non-prescription drugs? List: _____

_____

_____

Do you have any allergies? If so, to what? _____

Have you been warned against taking any medications? _____

Have you ever had an allergic or unusual reaction to any medication including penicillin, erythromycin, local anaesthetic (freezing) aspirin, codeine or latex? Please Specify: _____

Are you pregnant? _____ Are you taking birth control pills? _____

Have You Ever Had or Experienced: (CIRCLE IF **YES**)

congenital heart disease	HIV/AIDS	hepatitis A, B, or C	organ transplant	joint replacement
diabetes	blood disorders	bleeding problems	heart murmur	rheumatic fever
cancer	heart attack	mitral valve prolapse	epilepsy or seizures	liver disease
lung disease	thyroid disease	herpes	nervous disorder	kidney disease
drug addiction	asthma	anorexia/bulimia	radiation	chemotherapy
pacemaker				

Do you have any condition not mentioned? _____

When was your last dental visit? _____ When did you last have dental x-rays? _____

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

Do you smoke or chew tobacco? _____ Have you been seeing a dentist regularly? _____

Do any of your teeth ache? _____

Have you ever been advised to take antibiotics before a dental appointment? _____

Do your gums bleed when you brush? _____ Do you have any pain when you chew? _____

Have you ever been in a vehicle accident or experienced any blows to your jaw or face? _____

Have you had any implant surgery in one or both of your jaws or jaw joints? _____ If so, who performed the surgery and when was it done? _____

Are you being followed-up by a dental specialist? _____

Do you snore? _____

A portion of the health care services provided in connection with treatment at our facility are provided by Dr. Sanjeev Jaswal. This company is owned and operated by Dr. Sanjeev Jaswal. Fees charged for services provided by Dr. Sanjeev Jaswal are in accordance with the guidelines of the Ontario Dental Association.
I, the undersigned, certify that all the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary, as this information may be required for my dental care.

Signature: _____ Date: _____

PATIENT, PARENT (GUARDIAN) CONSENT

I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and will assume responsibility for fees associated with these procedures.
I also understand that there will be a $85.00 service fee applied to any NSF cheques.

Patient, Parent (guardian) Signature: _____ Date: _____

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 the named dentist.

This authorization shall continue in effect until the undersigned revokes the same.

_____ _____
Signature of patient, parent or guardian Date

I hereby assign my benefits, payable from claims submitted electronically to Dr. Sanjeev Jaswal and authorize payment directly to him.

This authorization shall continue in effect until the undersigned revokes the same.

_____ _____
Signature of patient, parent or guardian Date