

# Eglinton Oak Dental Centre

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

Male  Female /  Married  Single  Child  Other \_\_\_\_\_ Parent/Guard. Name: \_\_\_\_\_

Birth Date: (dd/mm/year) \_\_\_\_\_ Email: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_ Preferred method of contact: Home \_\_\_ Cell \_\_\_

Address: \_\_\_\_\_  
Street

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDS               | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Allergies _____    | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Venereal Disease   |
|   | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Hay Fever           | Due date: _____                               | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Radiation Treatment  | OTHER:                                      |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatic Fever      | _____                                       |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatism           | _____                                       |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems       |   |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Stomach Problems     |   |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stroke               |   |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Tuberculosis         |   |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders    | <input type="checkbox"/> Tumors               |   |

• Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: \_\_\_\_\_

Signature of patient, parent or guardian

## Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  Flyer  Website  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Province Postal Code

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: (dd/mm/year) \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

#### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: (dd/mm/year) \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

#### I ACKNOWLEDGE MY RESPONSIBILITY TO PAY THE CO-PAYMENT

\_\_\_\_\_  
Signature of patient, parent, or guardian

### Consent for Services

Welcome to our dental office. Our office will make sure that we look after your dental needs and give you the best treatment that will give you a healthy mouth.

**AS CONSIDERATION OUR OFFICE REQUIRES 2 BUSINESS DAYS FOR ALL CANCELLATIONS OR CHANGES.**

I will allow your office to send my insurance information over the internet to my insurance company. I will be responsible to pay for services rendered on the day of treatment unless special arrangements have been made.

Our office takes the Privacy Act very seriously and will make sure to follow proper protocols set in place.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_