RIVERSIDE Dental™

Dr. Lisa Kelly

MEDICAL/DENTAL INFORMATION

1465 Riverside Drive, Timmins, Ontario P4R 1M8
Tel: (705) 268-2401 Fax: (705) 268-6833

PATIENT INFORMATION

First Name: ________________________ Preferred Name: ___________ □ Married □ Single □ Child

Last Name: ____ Sex: □ Male □ Female

Address: ____ Home Tel: ______________________

City: ______________________ Postal Code: _____________ Work Tel: ______________________

E-mail: ____ Cell Phone: ______________________

S.I.N.:___________________ (*optional, used for collection purposes) Date of Birth: dd / mm / yyyy

How would you prefer to be contacted □ home □ work □ cell □ email □ text

Physician's Name: __________________________ Health Card Number: ________________________

Place of Employment and/or Name of School: ____

Names of other family members who are patients here: _______________________________________

How did you hear about our office? □ Friends □ Family □ Internet Site □Other: __________

If this medical is for a child please include:

Dad's Name: __________________________________ Date of Birth: dd / mm / yyyy

Place of Employment:___________________________ *S.I.N.: ____________________

Mom's Name: _________________________________ Date of Birth: dd / mm / yyyy

Place of Employment:____________________________ *S.I.N.: ____________________

MEDICAL HISTORY

1. Are you presently under the care of a physician for medical treatment? □ Yes □ No
   Please Explain: ____
2. Do you have any allergies? □ Yes □ No
   If yes, please specify: ____
3. Do you have a heart or circulatory problems of any kind? □ Yes □ No
   If yes, please explain: ____
4. Do you take aspirin or blood thinners on a daily basis? □ Yes □ No
5. Do you take any medication for osteoporosis (low bone density)? □ Yes □ No
6. Are you presently taking any medication, non-prescription drugs or herbal supplements? □ Yes □ No
   Pleases specify: a) ____________________________ reason ______________________
   b) ____________________________ reason ______________________
   c) ____________________________ reason ______________________
   d) ____________________________ reason ______________________
7. Do you presently have, or have you ever had any of the following?

Condition			Condition		
Anemia	□ Yes	□ No	Heart Murmur	□ Yes	□ No
Arthritis	□ Yes	□ No	Hepatitis	□ Yes	□ No
Asthma	□ Yes	□ No	HIV/AIDS	□ Yes	□ No
Blood Disorder	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Joint Replacement	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Diabetes	□ Yes	□ No	Lung Disease	□ Yes	□ No
Emphysema	□ Yes	□ No	Liver Disease	□ Yes	□ No
Epilepsy/Seizure	□ Yes	□ No	Pacemaker	□ Yes	□ No
Hay Fever	□ Yes	□ No	Stroke	□ Yes	□ No
Heart Attack	□ Yes	□ No			

8. Have you ever received treatment for cancer? □ Yes □ No Type:________________________
   If yes, what treatment did you receive and when?
   □ Radiation / Date ____________________ □ Chemotherapy / Date ______________________
9. Have you had any abnormal bleeding following previous extractions or operations? □ Yes □ No
10. Do you need to take pre-medication for your dental appointments? □ Yes □ No
11. When was your last physical done: _________________
12. Do you use tobacco products? □ Yes □ No If yes, how often per day? ___________________
13. Do you, or have you ever consumed alcohol and/or narcotic pain killers on a regular basis? □ Yes □ No
14. Have you ever had a general anaesthetic? □ Yes □ No Any complications? □ Yes □ No
    If yes, please specify: ____
15. FEMALES ONLY: Are you pregnant? □ Yes □ No If yes, what month are you in? _________

DENTAL HISTORY

1. When was your last dental visit? __________ Did it include a complete oral exam? □ Yes □ No
2. How often do you: Brush? _________ Floss? _________
3. Are your teeth sensitive? □ Yes □ No
   If yes, are they sensitive to: □ Hot □ Cold □ Sweets □ Other:__________________________
4. Do your gums bleed when: □ Brushing □ Flossing □ Spontaneously □ Never
5. Have you ever been diagnosed with periodontal disease?(gum disease) □ Yes □ No

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DENTAL INSURANCE

******Please be aware that all insurance deductibles and co-payments are the responsibility of the patient and are due on the day dental service is provided.**

Do you have dental insurance? □ Yes □ No

If yes,
Who is the holder of the insurance? ____
Address of holder if different: ____
Name of insurance company: ____
Policy holder's place of employment ____
Policy #: ______________________ I.D. #: ____________________________________
Policy holder's date of birth: d d / m m / y y y y

If your employer has set-up the insurance payment as non assignable to our office you are responsible to pay all fees in full on day of service.

OFFICE POLICY: Your appointment is reserved for you. If you are unable to attend your appointment, we do require a two business day notice in order to avoid cancelation fees.

Date : ______________________________ Signature : ______________________________
Parent or Guardian if patient is under 16 years of age.