Tooth Works Dentistry

MEDICAL-DENTAL ALERT

_____

PATIENT MEDICATION CURRENTLY BEING TAKEN:

_____

_____

_____

PERSONAL INFORMATION

NAME _____ DATE OF BIRTH ____/____/____ (MO / DAY / YR)

HOME ADDRESS _____ CITY/PROV. _____ POSTAL CODE_____

PHONE(H) _____ PHONE(W)_____ MARITAL STATUS_____

REFERRED BY _____ EMAIL ADDRESS _____

EMPLOYER _____ OCCUPATION _____

PERSONAL PHYSICIAN_____ PHONE _____

EMERGENCY CONTACT_____ PHONE _____

BILLING PROCEDURES

Our office policy is that your portion of the services are paid for at each visit as they are performed. In cases where the balance owing insurance is unknown, a credit card will be held on file to cover the patient portion. In cases where no credit card is available, payment of the balance is due within 10 days of notice. Failure to arrange payment within 10 days will result in the non-assignment of benefits for future claims. Alternate arrangements may be available upon request. We will prepare all necessary reports to help collect your benefits from insurance companies. Our fees are not based on insurance company fee guides.

INITIAL _____

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical/dental history. I authorize the dentist to perform diagnostic procedures and treatments as may be necessary for my dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted if necessary.

INITIAL _____

CANCELLATION POLICY

Notification of cancellation is required within 24 hours of your appointment time, or a fee will be charged.
We do NOT accept cancellations by voicemail or email.

INITIAL _____

INSURANCE INFORMATION

SIN _____

	Primary	Secondary
Insur. Co. Name	_____	_____
Member Name	_____	_____
Date of Birth	_____	_____
Policy/Group No.	_____	_____
I.D. / Cert. No.	_____	_____

MEDICAL HISTORY

Please check(✓)

	YES	NO
1. Have you ever had a serious Illness or are you under the care of a physician now?	○	○
2. Have you had a medical examination In the last year?	○	○
3. Have you ever had any of the following diseases? (Please Circle) Jaundice, diabetes, high blood pressure, tuberculosis, any lung disease, venereal disease, heart attack or heart disease, stroke, epilepsy, cancer, thyroid disease, kidney disease, mental or nervous disease, arthritis or rheumatic fever, stomach problems, allergies.	○	○
4. To your knowledge have you been In contact with the AIDS virus or Hepatitis?	○	○
5. Has any member of your family had diabetes?	○	○
6. Have you ever experienced any unusual reaction to any of the following drugs? (Please Circle) Aspirin, penicillin, Iodine, sulfonamide (sulfa), barbiturates (sleeping pills) , local anesthesia or other medicine or latex.	○	○
7. Do you bruise easily or bleed abnormally?	○	○
8. Are you pregnant? (Which month?)._____	○	○
9. Are you taking birth control pills?	○	○
10. Do you use tobacco products?	○	○

TEMPORO MANDIBULAR JOINT SCREENING EXAMINATION

Please check (✓)

	YES	NO
1. Have you ever been treated for problems of your jaw joint or facial muscles?	○	○
2. Are you aware of clenching, grinding, cheek/nail biting, lip biting, mouth breathing, other?	○	○
3. Do you have tension or migraine headaches?	○	○
4. Do you have difficulty opening your mouth?	○	○
5. Do you experience pain during yawning, chewing, speaking, or swallowing?	○	○
6. Do your Jaw muscles become tired frequently?	○	○
7. Have you had an Injury to your face or Jaws?	○	○
8. Are you aware of any clicking or unusual sensations from your jaw joint?	○	○

DENTAL HISTORY

Please check (✓)

	YES	NO
1. Has It been more than 1 year since your last dental exam? How long? _____	○	○
2. Do you have dental anxiety?	○	○
3. Would you like to improve your smile?	○	○
4. Do you have staining on your teeth that you would like removed?	○	○
5. Would you like to Improve the alignment of your teeth?	○	○
6. Do you have missing teeth you would like to have replaced?	○	○

7. What concerns you most about your dental health?

_____

_____

SIGNATURE _____ _____ _____

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NOTES

DATE	OPERATION	FEE

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