ALDERWOOD FAMILY DENTISTRY

Welcome Form

Our wish is to serve you better. This is why we ask that you complete this form to help expedite any future appointments and so that we get to know you better. All information provided to our office is confidential and protected by P.I.P.E.D.A & P.H.I.P.A (Government mandated privacy policies) **PLEASE PRINT CLEARLY.**

PERSONAL INFORMATION

Last Name: ____________________________________ First Name: ___________________________PrefeName_________________

Your Address: ____ Suite # _________________

City: ____ **Postal Code**: ____________________________________

Birthdate: Day _____ Mo______ Yr______ Gender: *Please Circle* M F

E-Mail: ____ **Home Phone:** ____________________________________

Work: __________________________________**Ext**:________ **Cell :** ____

Best way to contact you: *Please check one:* Home Phone_________ Cell Phone________ Email_______

Driver's License#:___________________________________ or Health Card ____

(This required for some prescriptions)

Emergency Contact: _______________________________________ Phone: ______________________ Relationship_______________

How did you hear about us, or who may we thank for referring you? ____

Do you speak any other languages? If so which ones?____

About Your Work: Occupation: _______________________Employer Name: __________________________________YRS ___________

INSURANCE INFORMATION

1. Your Insurance Company Name: ____Div ___________

If there is an administrator their Name: ____

Policy/Contract/Group #: ___________________________ Certificate/ID #: ______________________________________

2.Your Spouse's Dental Benefits Information or Secondary Insurance (if applicable)

Spouse Last Name: _____________________ First Name: ________________ Birthdate: Day _____ Mo _____Yr _____

Employer: _____________________________________ Insurance Company: ________________________Div________

Policy/Contract/Group #: _____________________ Certificate/ID #: ____

Have you used any of your insurance benefits within this benefit year? ____________________________________

If yes what was done and how long ago? ____

ALDERWOOD FAMILY DENTISTRY

In order for us to serve you better and safer we will need the following information.. All information will be strictly confidential. Please print clearly. . All information provided to our office is confidential and protected by P.I.P.E.D.A (Government personal information protection act). **PLEASE PRINT CLEARLY!**

MEDICAL HISTORY

Family Doctor Name: ____ Phone ____________________________________

Are you being treated for any medical condition at the present? Yes No If so what? ____

Please circle if you have had or have any of the following conditions:

Heart Condition	Anemia	Asthma	**Allergie**s_________________________ High
blood pressure	Diabetes	Epilepsy	Osteoporosis
Heart attack	Hepatitis A/B/C	Kidney problems	Hypoglycemia
Heart valve surgery	Stomach Problems	Liver problems	Smoker
Heart Murmur	Thyroid Disease	Cancer_____________	Pregnant ____MONTHS
Rheumatic fever	Chronic bronchitis	HIV related conditions	Arthritis
Bleeding problems	Emphysema	Prosthetic limb/organ	Stroke
Tuberculosis	Aids/HIV	Other ____	

Please list any current medications; including over the counter and vitamins or naturopathic medications (if you need additional space, please write on the back of this page):

____

Please list any allergies to Medicine:

____

DENTAL HISTORY

Date of most recent dental visit: __________________________________ What was done at the time ____________________________

I see my dentist every: _____3 month's _____4 month's _____6 month's ____12 month's _____Not routinely (when I have pain)

How would you rate the condition of your mouth? ________Excellent ________Good _________Fair ___________Poor

Does dental treatment make you nervous? *Please circle* No Slightly Moderately Extremely

We offer Nitrous Oxide to all our patients (laughing gas) to make you more comfortable during dental procedures. Would you be interested in having it during your dental procedures? *Please circle* YES NO

Please circle

Do you have bad breath? YES NO **Do your gums bleed?** YES NO **Are you self-conscious of your smile?** YES NO

What would you like to change about your smile or teeth? ____

Do your jaws hurt when you wake up? YES NO **Do you understand the importance of regular hygiene?** YES NO

Have you ever had local anesthetic (freezing?) YES NO **Were there any complications**? YES NO

Please circle if any of the following apply to you:

Bleeding gums	Unpleasant Taste/Bad Breath	Frequent Blisters	Swelling/Lumps in mouth
Ortho Treatment	Clicking/Popping Jaw	Difficulty chewing	Teeth Sensitivity hot/Cold
Clenching/Grinding	Headaches		

Have you ever had Botox treatment before? Yes No If yes, what was the reason? P*lease circle one:* Cosmetic Therapeutic

I understand the above information is necessary to provide me with dental care in a safe manner. I have answered all the questions to the best of my knowledge. Should further information is needed; the office has my permission to ask the respective health care provider to release such information. I will notify the office and dentist of any change in my health or medication. I understand that the office will do their best to work with my insurance company; however some insurance companies do not work with the dental offices and prefer to work directly with the patients. I understand that for any overdue fees a charge of 2% will apply. I understand that I am fully responsible for all the bills incurred in this office if the insurance does not honour the claims. I give authorization to the dentist to perform any treatment needed and to provide local anesthetic as is needed.

Signature: ____ Date: ______________________________

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