

**MEDICAL HISTORY**

General Health:                    Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever been hospitalized? ..... **Yes**                    **No**  
If yes, please indicate when and why? \_\_\_\_\_

Have you had any joint replacement surgery? ..... **Yes**                    **No**

Are you taking any medications or drugs? ..... **Yes**                    **No**  
If yes, please indicate all medications including oral contraceptives and aspirin. \_\_\_\_\_

Are you being treated for a condition now? ..... **Yes**                    **No**  
If yes, please indicate \_\_\_\_\_

Do you have any allergies? ..... **Yes**                    **No**  
If yes, please indicate \_\_\_\_\_

Do you have any allergies to medications? ..... **Yes**                    **No**  
If yes, please indicate \_\_\_\_\_

Do you have a latex allergy or sensitivity?..... **Yes**                    **No**

**Male                    Female**

If female, are you pregnant? ..... **Yes**                    **No**                    **Month** \_\_\_\_\_

Please circle if you have or if you have had any of the following: Check here \_\_\_\_\_ if none apply

- |                         |                      |                         |                         |                        |
|-------------------------|----------------------|-------------------------|-------------------------|------------------------|
| <b>Heart Trouble</b>    | <b>Liver Disease</b> | <b>Ulcers</b>           | <b>Heart Murmur</b>     | <b>Thyroid Disease</b> |
| <b>Arthritis</b>        | <b>Hepatitis</b>     | <b>Venereal Disease</b> | <b>Severe Headaches</b> | <b>HIV Virus</b>       |
| <b>Kidney Infection</b> | <b>Epilepsy</b>      | <b>Rheumatic Fever</b>  | <b>Tuberculosis</b>     | <b>Blood Disorders</b> |
| <b>Hypertension</b>     | <b>Sinus Trouble</b> | <b>Cancer</b>           | <b>Stroke</b>           | <b>Diabetes</b>        |
| <b>Glaucoma</b>         | <b>PKU</b>           |                         |                         |                        |

What is your immediate concern? \_\_\_\_\_

Name of previous dentist? \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever had local anesthetic (freezing)    **Yes**                    **No**  
If yes, any complications?                    **Yes**                    **No** If yes please explain \_\_\_\_\_

Do you have now, or have you had jaw symptoms, whiplash, or TMJ disease?                    **Yes**                    **No**  
If yes, please explain \_\_\_\_\_

Do you smoke?    **Yes**                    **No**                    Quantity per day? \_\_\_\_\_

Have you ever thought of quitting?    **Yes**                    **No**

Do you have dental implants? ..... **Yes**                    **No**

How often do you Brush? \_\_\_\_\_ Floss \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

DOB: \_\_\_\_\_ (m/d/y)

HOSPITAL # \_\_\_\_\_ S.I.N. \_\_\_\_\_

Next of Kin (not living with you) \_\_\_\_\_ Phone \_\_\_\_\_

I believe all the above information is true and complete.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**ACKNOWLEDGEMENT AND CONSENT**

I \_\_\_\_\_ acknowledge reviewing with \_\_\_\_\_, the Victoria Square Dental Privacy Policy and I understand my rights of privacy with respect to my personal information.

I further consent to the collection, use and disclosure of my personal information to provide me with dental health services, To maintain communications and provide me with information and follow up respecting my dental care and to obtain payment of my account. If I choose to restrict access of my personal information, I will notify Victoria Square Dental in writing of the particulars.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

How did you hear about us?    **Phonebook**                    **Location**                    **Word of mouth**                    **Other**

Please indicate whom so that we may thank them: \_\_\_\_\_

Therapeutic Alert

**BUSINESS INFORMATION**

We prefer payment after each visit as service is provided. A deposit is required on items from the dental laboratory. (ie. crowns and dentures)

Please indicate your preference:

- Cash
- Cheque
- Assignment \*
- Credit card (VISA or Mastercard)
- Interac
- Other \*

\* Please see the receptionist to make other arrangements prior to treatment.

**PRIMARY INSURANCE**

NAME OF INSURANCE COMPANY \_\_\_\_\_

GROUP/POLICY NUMBER \_\_\_\_\_

DIVISION NUMBER \_\_\_\_\_

SUBSCRIBER ID / CONTRACT NUMBER \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ (m/d/y) S.I.N. \_\_\_\_\_

**SECONDARY INSURANCE**

NAME OF INSURANCE COMPANY \_\_\_\_\_

GROUP/POLICY NUMBER \_\_\_\_\_

DIVISION NUMBER \_\_\_\_\_

SUBSCRIBER ID / CONTRACT NUMBER \_\_\_\_\_

RELATIONSHIP - \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ (m/d/y) S.I.N. \_\_\_\_\_

**INSURANCE FOR YOUR CHILDREN**

The insurance companies have decided that for your children, the parent whose birthday is first in the year, will be the Primary Insurance.

**CREDIT INFORMATION**

Visa or Mastercard \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Exp Date \_\_\_\_\_

Bank \_\_\_\_\_ Branch \_\_\_\_\_

(obtain voided cheque blank or xerox copy of one)

I hereby assign my benefits payable from claims submitted electronically or mailed to Dr. K. Soltys and authorize payment directly to him.

I understand that I become responsible for my account if it is not paid within 30 days. I am also responsible for any portion of my bill that is not covered by my dental insurance and it is due immediately upon receipt of statement

Signature of subscriber \_\_\_\_\_

**I AUTHORIZE RELEASE TO MY INSURING COMPANY PLANS ADMINISTRATOR, THE INFORMATION CONTAINED IN CLAIMS SUBMITTED ELECTRONICALLY.**

**SIGNATURE OF PATIENT/PATIENT GUARDIAN** \_\_\_\_\_

**DATE** \_\_\_\_\_

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

Name: \_\_\_\_\_ HOME ADDRESS: \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL NUMBER \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_