Welcome

Patient Contact Information

□ Mr □ Mrs □ Ms □ Miss □ Dr First Name:_____ Last Name: _____
Preferred Name: _____ Date of Birth: _____(DD/MM/YY) Gender: _____
Address:_____ Apt/Unit#:_____
City: _____ Province:_____ Postal Code: _____
Home Telephone Number: _____
E-mail address: _____
Work Number:_____ext. _____
Cell Number:_____ Employer: _____
_____
In case of an emergency – Please notify_____Phone Number:_____

May we send you emails about important office notifications, including appointment reminders? □ Yes □ No
May we send you text message appointment reminders? □ Yes □ No
You have the option to withdraw your consent at any time.

Referral Information

How did you hear about us? (Check all that apply)

□ Google/Website	□ Friend/Family Member.....Name:	_____
□ Dawson Sign	□ Flyer..... Flyer description:	_____
□ Mobile Sign	□ Radio.....Station(s):	_____
□ Email	□ Ad Perks/Work Perks	_____
□ Television	□ Insuarance Network	_____
□ Social Media	□ Other..... Please specify:	_____

Insurance Information

Primary Insurance Company Information
Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)
Policy Holder Contact Phone Number: _____ (if different from above)
Group Policy/Plan Number: _____ I.D./Certificate Number:_____
Marital Status: □ Single □ Married/Common Law □ Other
Insurance Company Name: _____
Secondary Insurance Company Information
Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)
Policy Holder Contact Phone Number: _____ (if different from above)
Group Policy/Plan Number: _____ I.D./Certificate Number:_____
Insurance Company Name: _____

Responsible Party Signature: _____

DAWSON DENTAL CENTRE

Medical History

Please check any of the following that apply to you:

- □ *Heart condition*
- □ *Angina*
- □ *Heart surgery/procedures*
- □ *Heart attack*
- □ *Stroke/T.I.A*
- □ *Heart murmur*
- □ *Mitral valve prolapse*
- □ *Congenital heart disease*
- □ *Infective Endocarditis*
- □ *Pacemaker*
- □ *High blood pressure*
- □ *Low blood pressure*
- □ *General Anesthetic complications*
- □ *Diabetes: Type I or II*
- □ *Hypolglycemia*
- □ *HIV positive/AIDS*
- □ *Anemia*
- □ *Blood disorders*
- □ *Hepatitis A/B/C*
- □ *Hemophilia*
- □ *Excessive bleeding/bruising*
- □ *Immunedeficiencies*
- □ *Eating disorder*
- □ *Lupus*
- □ *Thyroid disease*
- □ *Kidney disease*
- □ *Liver disease*
- □ *Joint replacement*
  joint _____
  date _____
- □ *Cancer - type:* _____
  Date
  Radiation:
  Chemotherapy:
  Surgery
- □ *Asthma*
- □ *Respiratory conditions*
- □ *Tuberculosis*
- □ *Snoring/sleep apnea*
- □ *Dizziness/fainting*
- □ *HPV*
- □ *Herpes/cold sores*
- □ *Ulcers/acid reflux*
- □ *Intestinal/stomach problems*
- □ *Above average weight gain/loss*
- □ *Vision Impairment*
- □ *Hearing impairment*
- □ *TMJ (jaw joint) concerns*
- □ *Physical impairment*
- □ *Arthritis*
- □ *Osteoperosis*
- □ *Long-term Actonel/Fosomax use*
- □ *Epilepsy/seizures*
- □ *Cognitive impairment*
- □ *Depression*
- □ *Anxiety*
- □ *Mental health issues*
- □ *Drug/alcohol dependency*
- □ *Tobacco Use*
- □ *Other*_____

Do you have any allergies or sensitivities to **Medications:** _____

Food: _____

Environment: _____

Has your physician ever told you to take antibiotics prior to dental procedures? □ Yes □ No

Have you ever experienced complications following a medical or dental procedure? □ Yes □ No

Are you pregnant? □ Yes □ No If yes, how many weeks? _____ weeks

Is there anything else you think we should know regarding your medical history? □ Yes □ No

If yes, please describe. _____

Are you taking any medications? □ Yes □ No *If yes, please specify* _____

_____

Family Physician's Name: _____ Physician's Phone Number: _____

Privacy & General Information

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. If required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided.

Consent for Collection, Use and Disclosure of Personal Information

I agree that Dawson Dental Centre has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

At our office, all professional dentistry services are performed by licensed members of the Royal College of Dental Surgeons (the "**Dental Professionals**"), and all institutional health care services are performed independently by Dawson Health Services under the clinical supervision and control of Dental Professionals, in a cost-sharing arrangement. Dawson Dental Centre and Dawson Health Services are independent corporations providing independent services but for ease of administration they may render joint invoices for their respective services. One or more of our Dental Professionals has a financial interest in Dawson Health Services. By signing this form, the undersigned acknowledges and agrees that they have read and understood the information and disclosure set forth herein prior to any professional services being provided to the undersigned by any Dental Professionals working with Dawson Dental Centre.

Signature: _____ Date: _____

Patient (Please Print): _____

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