DR. ANNA ISAACS
DENTISTRY

Patient Information

First name: _____ Last name: _____

Name of Parent/Legal Guardian (if applicable): _____

Sex: M ☐ F ☐ Other ☐ Date of Birth: _____(DD/MM/YYYY)

Email: _____

Street Address: _____ Apt#: _____

City: _____ Province: _____ Postal code:

_____

Phone number: (____) _____ (Cell)

: (____) _____(Home/other)

Emergency Contact: _____Phone Number: (____) _____

Relationship: _____

How did you hear about us? :_____

Insurance Information

Insurance Yes☐ No ☐ if yes, Insurance provider: _____

Subscriber Name/Date of birth: _____ /_____(DD/MM/YYYY)

Relationship to patient: Self ☐ Spouse ☐ Child ☐ Other ☐

Group/Policy #: _____ Certificate/ID #: _____

Please note we only accept primary insurance; you are responsible for submitting to any secondary insurance.

General Information

Previous Dentists Name: (optional) _____

Approximate date of your last hygiene visit: _____ (DD/MM/YYYY)

What is the reason for your visit today? _____

Do you have any aesthetics concerns about your smile?

_____

Is there anything about your previous dental experiences that we should be aware of?

_____

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Dental History

Please indicate if you have any of the following:

	Yes	No		Yes	No
Bad Breath	☐	☐	Previous Ortho treatment	☐	☐
Bleeding gums	☐	☐	Previous gum grafting	☐	☐
Canker sores	☐	☐	Dental Implants	☐	☐
Food collecting between certain teeth	☐	☐	Loose teeth	☐	☐
Headaches	☐	☐	Lumps or growths in your mouth/face	☐	☐
Clenching and/or grinding	☐	☐	Pain in your joint, ear or side of face	☐	☐
Difficulty opening or closing	☐	☐	Sensitivity to hot, cold, sweet or chewing	☐	☐

Medical History

Family Doctor: _____ Pharmacy: _____

Have you ever had any serious illness or operation Yes ☐ No☐ if yes, what, and when?

_____

Have you ever been tested for sleep apnea? Yes☐ No ☐

If yes, what was the diagnosis? _____

If applicable; Are you pregnant? Yes ☐ No☐ Are you Nursing? Yes ☐ No ☐

Do you smoke? No☐ Yes ☐ if yes: Cigarettes ☐ Vape ☐ Marijuana ☐ Chewing tobacco ☐

Do you use recreational drugs? Yes☐ No ☐ if yes, what? _____

Have you ever been advised by a physician to take antibiotics before dental treatment? Yes ☐ No ☐

Medications

Medication (including vitamins)	Reason for taking?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Allergies

Penicillin ☐ Yes ☐No Codeine ☐Yes ☐No

Latex ☐ Yes ☐No Ibuprofen/Advil ☐Yes ☐No

Other (Please list ALL other allergies):

_____

Please indicate where you do or do not have any of the following conditions:

	Yes	No		Yes	No
Tuberculosis	☐	☐	Heart problems	☐	☐
Anemia	☐	☐	Stroke	☐	☐
Arthritis rheumatism	☐	☐	Congenital heart lesions	☐	☐
Artificial heart valve	☐	☐	Epilepsy	☐	☐
Artificial joints, pins etc.	☐	☐	Fainting	☐	☐
Asthma/respiratory disease	☐	☐	Stomach or duodenal ulcer	☐	☐
Bleeding abnormally/Hemophilia	☐	☐	HIV/AIDS	☐	☐
Blood disease	☐	☐	Kidney disease	☐	☐
Cancer:_____	☐	☐		☐	☐
_			Liver disease		
Chemotherapy/Radiation	☐	☐	Rheumatic/Scarlet fever	☐	☐
Head/Neck injury	☐	☐	Pacemaker	☐	☐
Drug dependency	☐	☐	Autoimmune disorder	☐	☐
Alcohol dependency	☐	☐	Diabetes(Type):_____	☐	☐
	☐	☐	Hepatitis(Type):_____	☐	☐
Thyroid disease Hypo Hyper			_		
Blood pressure ☐High ☐Low	☐	☐	Eating disorder	☐	☐

Please list any additional medical conditions that may not be listed above:

_____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I CONSENT TO THE TAKING OF RADIOGRAPHS AND PHOTOGRAPHS BEFORE, DURING AND AFTER TREATMENT ON MY BEHALF OR MY DEPENENTS. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

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Signature of Patient/legal Guardian of Minor:_____ Date:_____