KANATA ENDODONTICS

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CONFIDENTIAL PATIENT INFORMATION

* Please Print *

Dr. Mrs. Miss Mr. Ms. Other

Name: _____ Gender: _____
Last Given Middle

Home Address: _____
Street City Postal Code

Home Phone: ( ) _____ Bus. Phone: ( ) _____

Date of Birth: _____ Cell (optional): ( ) _____
Day Month Year

Family Physician and/or Medical Specialist: _____

Address: _____ Phone: ( ) _____

Emergency Contact Person: _____ Relation: _____

Home Phone: ( ) _____ Bus Phone: ( ) _____

Applicable Parent or Guardian: _____ Phone: ( ) _____

Who referred you to our practice? _____

Health Card or Driver's License Number _____

E-mail address _____

DENTAL INSURANCE

NOTE: THIS INFORMATION IS ONLY REQUIRED SHOULD YOU WISH US TO ELECTRONICALLY SUBMIT YOUR CLAIM.

Name of Primary Subscriber: _____

Subscriber's Date of Birth: _____ Insurance Company: _____
D M Y

Policy No.: _____ ID / Cert. No.: _____

Employer: _____ If you have 2 insurance plans, please indicate below.

Secondary Subscriber: _____ Date of Birth: _____
D M Y

Policy No.: _____ ID / Cert. No.: _____

Insurance Company: _____ Employer: _____

FINANCIAL INFORMATION

Preferred method of payment: ☐ Visa ☐ Mastercard ☐ Cash ☐ Interac

If a minor, person responsible for the account _____

Please Turn Over...

MEDICAL HISTORY

In the following questions, circle yes or no, whichever applies.

1. Has there been any change in your medical history within the past year? ..... YES NO

2. Are you allergic to or have you reacted adversely to any medications? i.e. penicillin, local anaesthetic ..... YES NO
   please list: ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Other Antibiotics
   Others _____
   _____

3. Are you allergic or have you reacted adversely to any latex or rubber products? ..... YES NO

4. Are you taking any medications, non-prescription drugs, cannabis or herbal supplements? ..... YES NO
   please list _____
   _____

5. Are you being treated for any medical condition at the present time or within the past year? ..... YES NO
   please list _____
   _____

6. Have you ever been hospitalized for any illnesses or operations? ..... YES NO
   please list _____
   _____

7. Are you required to take antibiotics before dental treatment? ..... YES NO

8. Check (✓) if you have or have had any of the following diseases or conditions:

☐ Heart murmur	☐ Chest pain / Angina	☐ Hepatitis / Jaundice	☐ Tuberculosis
☐ Rheumatic fever	☐ Artificial joints	☐ Liver disease	☐ AIDS / HIV+
☐ Mitral valve prolapse	☐ Stomach ulcers	☐ Kidney disease	☐ Diabetes
☐ Heart disease / Stroke	☐ Seizures / Epilepsy	☐ Asthma/ Lung disease	☐ Thyroid disease
☐ High blood pressure	☐ Bleeding problem / disorder		

9. Are there any conditions and/or diseases not listed above that you have or have had? ..... YES NO
   If yes, please list _____

10. **For women only**: Are you breast feeding or pregnant? ..... YES NO
    If pregnant, please indicate expected delivery date _____

INFORMED CONSENT

I consent that I have accurately completed the registration and medical/dental histories to the best of my knowledge, and have not knowingly omitted any information. The information has been reviewed with me, and my questions answered.

I understand that I am financially responsible for the doctor's services.

I have reviewed the document titled "PATIENT INFORMATION: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION" that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that Dr. Mario J. D'Addario, Dentistry, Professional Corporation can collect, use and disclose personal information about me, as set out in the information about the office's privacy policies.

_____ _____ _____

Signature Date Signature of Witness

Dentist's Signature _____ Date _____