

SOUTHPOINTE DENTAL

ADULT PATIENT QUESTIONNAIRE

Today's Date _____
Day/month/year

Name		Date of Birth
Home Address		
City	Province	Postal Code
Home Phone #	Work Phone #	Cell Phone #
Employed By	How long	Occupation
Marital Status	Name of Spouse	E-mail Address
SIN #	D.L. #	
Personal Physician	Phone #	
Nearest Relative not living with you	Relationship	
Address		Phone #
City	Province	Postal Code

INSURANCE

Primary Insurance Company	Employee Name	Employer
SIN #	Date of Birth	
Group/Policy #	ID #	% covered
Secondary Insurance Company	Employee Name	Employer
SIN #	Date of Birth	
Group./Policy #	ID #	% covered
Name of person responsible for this account		
WHOM MAY WE THANK FOR REFERRING YOU?		

OFFICE POLICY

Our office policy is that services are paid for in full at each visit as they are performed. If you are unable to keep your appointment, we will require 24 hours notice, otherwise it may be necessary to charge for time lost. We have the right to charge interest on accounts over 60 days in arrears (1.5% month/19.6% per annum).

ALL CHARGES INCURRED WITH RESPECT TO YOUR ACCOUNT ARE YOUR FULL RESPONSIBILITY

Privacy Act Information: *The Health Information Act, is a new government policy which is designed to control the information health providers collect and share. Our office requires medical histories on patients to ensure a high level of care, in addition personal information is required to enable us to keep in touch for ongoing care. We take an active role in contacting patients with outstanding treatment and to remind them of future appointments and ongoing treatment requirements. The office may share radiographs (x-rays), records, and photographs with insurance companies, specialists, pharmacists, physicians and other dentists. We are pleased to provide you and your family with dental care and will share personal information only when, in our opinion, it is for the individual patient's best interests.*

The undersigned hereby authorizes Southpointe Dental the authority to obtain or deliver information through credit reporting agencies if financial arrangements are required or delinquent accounts are existing. I also acknowledge that all dental fees incurred are my responsibility.

Patient Signature _____ Date _____

Parent or Guardian if Minor _____ Relationship _____

ADULT MEDICAL INFORMATION

Are you experiencing pain or discomfort? _____ When was your last dental visit? _____

Are you in good health? _____ Has there been a change in your general health within the past year? _____

Are you under the care of a physician? _____ If so, what condition is being treated? _____

Physician's Name _____ City _____ Phone # _____

Have you been hospitalized or had a serious operation or illness within the last 5 years? _____

Do you have or have you had any of the following diseases or problems? Please circle any that apply:

Heart Failure, Disease or Attack	Emphysema	Diabetes
Angina Pectoris	Cough	Thyroid Disease
High Blood Pressure	Tuberculosis (TB)	X-ray or Cobalt Treatment
Heart Murmur	Asthma	Chemotherapy (Cancer)
Rheumatic Fever	Hay Fever	Rheumatism
Congenital Heart Condition	Sinus Trouble	Cortisone Medicine
Scarlet Fever	Allergies or Hives	Arthritis
Artificial Heart Valve	Artificial Joint	Glaucoma
Heart Pacemaker	Anemia	Pain in Jaw Joints
Heart Surgery	Stroke	Fainting or Dizzy Spells
AIDS or HIV-related disorders	Kidney Trouble	Epilepsy or Seizures
Hepatitis A or B	Ulcers	Cold Sores
Liver Disease	Bruise easily	STD or VD (Syphilis, Gonorrhea)
Yellow Jaundice	Sickle Cell Disease	Blood Transfusion
Psychiatric Treatment	Nervousness	

Are you taking any drugs or medicine? _____ If yes, what drugs or medicines _____

Are you allergic or have you reacted adversely to any drugs or medicines? _____ If yes, what drugs or medicines? _____

Please circle any others which apply:

Aspirin	Erythromycin	Novocain/Xylocain	Scopiamine
Codeine	Local Anesthetic	Penicillin	Sleeping Pills
Darvon	Nembutal/Seconal	Percodan	Tetracycline
Demerol	Nitrous Oxide	Other Antibiotics	Valium

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest? _____

Do your ankles swell during the day? _____

Have you had any serious trouble associated with any previous dental treatment? _____ If yes, please explain _____

Have you had abnormal bleeding associated with previous extractions, surgery or trauma? _____

Is there any history of family disease? _____

Do you have a disease, condition or problem not listed above that you think I should know? _____

Women Only:

Are you pregnant? _____ If so, due date: _____

Are you on birth control? _____

TREATMENT AND MEDICAL CONSENT

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anaesthetic as indicated.

I acknowledge the above information to be accurate and true to the best of my knowledge.

Patient Signature _____ Date _____

Parent or Guardian if minor _____ Relationship _____