

EMERGENCY TREATMENT INFORMATION

Last Examined by Family Doctor _____
 Last visit to a dentist _____
 Are you presently under the care of a physician? _____
 Is your health good? _____

Medical History

(Please mark the appropriate square)

- YES NO
- Are you taking any medication or drugs?
 - Have you been warned against taking any medications or chemicals?
 - Have you any allergies, hay fever or asthma?
 - Have you ever experienced any unusual reaction to local or general anesthesia?
 - Do you have any blood disorders?
 - Have there been any recent changes in weight, thirst or appetite?
 - Have you ever had injury, surgery or radiation therapy to your head, face or jaw?
 - Have you had any major surgery?
 - Have you ever had liver or kidney disease?
 - Have you ever had rheumatic fever?

If you have ever had or been treated for any of the following, please circle:

Scarlet fever, Tuberculosis, diabetes, heart attack, or heart disease, stroke, epilepsy, gall bladder disease, high blood pressure, cancer, lung disease, thyroid disease, mental or nervous disease, stomach ulcer, jaundice, AIDS, HIV, herpes, venereal disease, Hepatitis

If you have answered YES to any of the above questions, please specify:

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 _____ Relationship _____
 (if minor)

SOUTHPOINTE DENTAL

Emergency Chart

Date _____

Name		Province		Postal Code
Address				
City	Work Phone	Cell Phone		
Home Phone	Email Address			
Employer	SIN #			
Birth Date	Weight			
Spouse/Parent (Guardian)				
Nearest Relative not living with you				
Address				
City	Province	Postal Code		
Phone	Relationship			

INSURANCE

Primary Insurance Company		Employer
Employee Name	Date of Birth	
SIN #	ID #	% covered
Secondary Insurance Company		
Employee Name	Employer	
SIN #	Date of Birth	
Group/Policy #	ID #	% covered

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% monthly/19.6% per annum).

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

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 _____ Relationship _____
 (if minor)

WHAT IS THE PURPOSE OF YOUR VISIT?
