Welcome to Parkgate Village Dental Centre

Please complete the following confidential information:

PERSONAL INFORMATION

Date:_____

Surname: Mr/Mrs/Miss/Dr_____ Given Name:_____

Telephone: Home:_____Work:_____ Cell:_____

Address:_____

City:_____ Province:_____ Postal Code:_____

Date of Birth: Day:_____ Month:_____ Year:_____

Person responsible for account(policy holder):_____ Email address:_____

- ***Who may we thank for referring you?(please circle)***
  Dental Association
  Newspaper
  Outside Office Sign
  Phone Book
  Website / Internet
  Friend (Name)_____
  Family Member (Name)_____
  Staff Member (Name) _____
  Other _____

DENTAL INSURANCE INFORMATION:

Do you have dental Insurance coverage? Yes/No

Are you covered under a second dental plan? Yes/No

NOTE: please be aware of any limitations to your plan since responsibility for your account belongs to you. Our staff will gladly hand your insurance details.

DENTAL QUESTIONNAIRE

1. Are you in pain or discomfort? Yes/No
2. What are your reasons for visiting our dental office? _____
   _____
3. Please provide the approximate date of your last dental check-up _____
4. Are you satisfied with your teeth? Chewing Yes/No
   Aesthetics Yes/No
   Speech Yes/No

5. Do you experience any of the following problems? (please check)

- Swelling, sores or lumps in the mouth
- Sensitive teeth
- Bleeding gums
- Loose tooth
- Grinding or clenching habits
- Frequent headaches
- Clicking or popping noises from jaw joints
- Tension or pain from headaches, neck or shoulders
- Ringing in the ears
- Balance problems
- Pain in the jaw joints

6. Are you currently being treated by a physiotherapist or chiropractor for any neck, shoulder or spinal problems? Yes/No

7. Have you ever had any of the following treatments? (please check)

- Bridges or crowns
- Partial dentures
- Extractions
- Periodontal (gum) treatments
- Orthodontics
- Complete dentures
- Surgery in the mouth
- Root canal fillings

8. Have you ever had a traumatic experience in the dental office? If yes, please explain. Yes/No

9. Is there any particular dental treatment which makes you feel nervous, anxious or nauseous? Please explain

_____

PATIENT CONSENT:

I, the undersigned, hereby authorize the dentist to take X-rays, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis. I consent to the dental treatment agreed upon and also understand that the use of anaesthetic agents embodies a certain risk. I understand that a possibility of complication exists for each treatment. I authorize the doctor to perform any and all forms of treatment that may be indicated, and consent to the use of local anaesthetics. However, I reserve the right to refuse one or any of the above recommended treatments. I acknowledge that my questions have been answered to my satisfaction. I understand that responsibility for payment for dental services rendered in this office is expected at the end of each appointment unless financial arrangements have been made. Furthermore, I authorize release of my information from my dental plan administrator and consent to electronic submission of my dental claims.

Signature _____ Date _____

Signature of parent or guardian (if under 19) _____