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laserdentist@minorudental.com

changing how you feel about visiting the dentist

no needle, no pain, no numb lip
laser treatments for many dental procedures

1. PLEASE CALL TO MAKE AN APPOINTMENT
2. COMPLETE THIS FORM TO SAVE TIME
3. PRESENT IT TO THE RECEPTIONIST UPON ARRIVAL FOR YOUR FIRST APPOINTMENT

CONFIDENTIAL PATIENT RECORD

PERSONAL INFORMATION

Dr. Mr. Mrs. Ms Miss Other _____

Name: *Last* _____ *First* _____

Address _____

City/Province _____ Postal Code _____

Phone: *Residence* (_____) _____ *Business* (_____) _____

Date of Birth ____/____/____ Sex M F

Occupation/Employer _____

Whom may we thank for referring you? _____

In case of emergency, please contact _____ Phone (_____) _____

S.I.N. _____ Drivers License No. _____

Dental Insurance: No Yes Insurance Carrier _____

Dental Policy Numbers _____

How do you wish to pay for your dental services? Cash Cheque VISA MasterCard

HEALTH QUESTIONNAIRE

1. Have you ever had an unusual allergic reaction to any drugs or medicine? No Yes
To what? i.e. Penicillin, Codeine _____
2. Is your physician treating you now? No Yes
3. Are you taking any medicines or tablets? What? No Yes
4. Have you ever been hospitalized for any length of time? No Yes
5. Have you any allergies? No Yes
6. Have you had any abnormal bleeding? No Yes
7. Do you experience shortness of breath? No Yes
8. Have you heart disease or murmur? No Yes
9. Are your ankles often swollen? No Yes
10. Have you ever had radiation therapy? No Yes
11. Do you or have you ever had? *PLEASE CIRCLE*

Heart trouble	Diabetes	Blood Disorders	Artificial joints/Heart Valves
High Blood Pressure	Epilepsy	Anaemia	Nervous Problems
Rheumatic Fever	Thyroid trouble	HIV Virus/AIDS	Chest Pain
Kidney trouble	Tuberculosis	Hepatitis	Cancer
Liver trouble	Asthma	Stroke	Sinus Problems

Any others _____
12. For women only: Are you pregnant? No Yes
Physician's Name _____ Physician's Phone (_____) _____

DENTAL HISTORY

1. How long since your last dental visit? No Yes
2. Do you have any habits such as clenching, grinding your teeth? No Yes
3. Do you get food caught between any teeth? Where? No Yes
4. Do you currently experience any popping, clicking or pain in jaw joints? No Yes
5. Are you having sensitivities to sweets or cold or hot? No Yes
6. Do your gums feel tender or swollen or bleed when brushing? No Yes
7. Are you satisfied with the appearance of your teeth? No Yes
8. Describe what you would like us to do for your teeth? (i.e. what are the reasons you are seeking treatment)

CONSENT FOR TREATMENT

This is to certify that I, the 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 and I will assume responsibilities for fees associated with those procedures. I acknowledge and understand that Minoru Dental Centre DOES NOT have contracts with any of the dental insurance carriers and I am responsible for outstanding balances. I hereby authorize Minoru Dental Centre to obtain credit information if required.

Patient's (Parent's) Signature _____ Date _____

Person responsible for account _____