Welcome

Patient ID # ____________

Medical Alert ____________

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. PLEASE PRINT.

Patient Information:

A parent or guardian will be responsible for decisions on my treatment ☐ Yes ☐ No

Name: ____
First Initial Last

Address: ____
Street Apt City Prov. Postal Code

Date of Birth: ________ /_______/ ________ Home Tels.: ______________________
Day Month Year

Cell.:__________________________ Work Tel.: ____________________

Marital Status: ________________________________ Occupation: ____________________

Emergency Contact: ________________________________ Tel.:____________________

Family Doctor: ________________________________ Tel.:____________________

Financial Information:

Method of payment: Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other ☐

Person responsible for financial matters: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

IF DIFFERENT FROM ABOVE

Name:____
First Initial Last

Address: ____
Street Apt. City Prov. Postal Code

Date of Birth ____/____/____ Home Tel.: ______________________Work Tel.: ____________________
D M Y

Driver's Lic.: ______________________________ **OR** SIN#: ____________________

Policy Holder (If different from self) ____________________________________

PRIMARY INSURANCE

Ins. Company: ______________________________ Tel.: ____________________

Employer: ______________________________ Ins. Yr. End:____________________

Policy #:________________ Certificate #: ____________________ ID/SIN #:____________________

Max. Cov. ______________ % coverage for ______ Basic ______ Maj. Restorative __________ Orthodontic

SECONDARY INSURANCE

Ins. Company: ______________________________ Tel.: ____________________

Employer/Policy Holder; ______________________________ Ins. Yr. End:____________________

Policy #:________________ Certificate # : ____________________ ID/SIN #:____________________

Max. Cov. ______________ % coverage for ______ Basic ______ Maj. Restorative __________ Orthodontic

GENERAL RELEASE

OFFICE POLICE (Please Read)

1. All professional services are the direct financial responsibility of the patient. We will where possible bill your insurance company directly. However, any outstanding balance is the responsibility of the patient.
2. In the event that any balance greater than 90 days remains unpaid on my account, or any account for which I am responsible for, either through insurance, sell pay, N.S.F. cheque or any other method. I hereby authorize Dr. Solomon & Kazdan's Office to charge to my Visa/MasterCard in the amount owing. I understand also that a late payment penalty and or Bank charge may be added to my balance.
3. Authorize my insuring company plan administrator to release the information of this claim through EDI.

______________________________ ______________________ ____________________
Signature ☐ Self ☐ Parent/Guardian Print name Date

Medical History

(this information will remain confidential) Date ______________________

	Yes	No
1. Are you presently under the care of a physician? If so, explain ______	☐	☐
2. Have you ever been hospitalized? Explain ______	☐	☐
3. Are you taking any drugs or medication at this time? ______	☐	☐

A) Drug ______ Reason ______
B) Drug ______ Reason ______
C) Drug ______ Reason ______

4. Have you ever had any adverse effect to any of the following: **Antibiotic**-Penicillin ☐, Sulfonamide ☐, Other ☐, **Aspirin** ☐ ;
Barbiturates (sleeping pills) ☐; **Codeine** ☐; **Darvon** ☐; **Local Anaesthetic** ☐; **NONE** ☐

	Yes	No
5. Have you ever been warned against using any other medications? Which? ______	☐	☐
6. Have you ever taken prolonged medical or non-medical drugs? Which? ______	☐	☐
7. Do you suffer from any allergies (hay fever, latex etc.)? Which? ______	☐	☐
8. Do you bruise easily or have prolonged bleeding? ______	☐	☐
9. Do you smoke? How much per day? ______	☐	☐
10. Have you ever fainted, had shortness of breath or chest pains? ______	☐	☐

11. **WOMEN** Are you pregnant? Yes ☐ No ☐ Using birth control? Yes ☐ No ☐ Reached menopause? Yes ☐ No ☐

12. Do you have or have you ever had any of the following? Please ✔ appropriate boxes. **NONE** ☐

☐ A.I.D.S.	☐ Cortisone/steroid	☐ High/Low Blood pressure	☐ Psychiatric disorders
☐ Anemia	☐ Diabetes	☐ H.I.V. Positive	☐ Radiation/Chemotherapy
☐ Angina pectoris	☐ Drug/alcohol dependence	☐ Hodgkin's disease	☐ Rheumatic/Scarlet fever
☐ Anorexia nervosa	☐ Emphysema	☐ Hyper (Hypo) Glycemia	☐ Sickle Cell disease
☐ Artificial Heart valve	☐ Epilepsy	☐ Hypertension	☐ Sinus trouble
☐ Arthritis/rheumatism	☐ Glandular disorders	☐ Jaundice	☐ Stomach/intestinal problems
☐ Artificial joints (hips, knees)	☐ Glaucoma	☐ Kidney disease	☐ Stroke
☐ Asthma	☐ Head/Neck injuries	☐ Liver disease	☐ Thyroid disease
☐ Blood disorders	☐ Heart disease/attack	☐ Leukemia	☐ Tuberculosis
☐ Bronchitis	☐ Heart Murmur	☐ Lung disease	☐ Ulcers
☐ Bulimia	☐ Heart pacemaker/surgery	☐ Malignant hypothermia	☐ Venereal disease
☐ Cancer	☐ Heart rhythm disorder	☐ Mental/nervous disorder	☐ Other ______
☐ Circulation problems	☐ Hepatitis A/B/C	☐ Mitral valve prolapse	☐ Other ______
☐ Congenital heart lesions	☐ Herpes	☐ Organ transplant/implant	☐ Other ______

13 **CHILDREN** Have you recently had any of the following (approximate date)?

☐ Chicken Pox ______	☐ Measles ______	☐ Mumps ______
☐ Strep Throat ______	☐ Tonsillitis ______	☐ NONE ______

Dental History

1 What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other ______
2 How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Other ______
3 When was your last dental visit? ______ Last X-Ray? ______
4 How often do you brush per day? ______ Floss? ______ Use anti-bacterial rinse? ______
5 Are you teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other ______
6 Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never

	YES	NO
7 Do your gums feel swollen or tender? ______	☐	☐
8 Do you have bad breath or a bad taste in your mouth? ______	☐	☐
9 Do your jaws crack, pop or grate when you open widely? ______	☐	☐
10 Do you grind or clench your teeth? ______	☐	☐
11 Do you have food catch between your teeth? ______	☐	☐
12 Have you ever had local anaesthetic (freezing)? ______	☐	☐
Any complications? ☐ Yes ☐ No Specify ______	☐	☐
13 Have you ever had any problems with previous dental treatments? Specify ______	☐	☐

14 Have you ever had any of the following: ☐ Bridgework ☐ Crowns or Caps
☐ Full or Partial Dentures ☐ Orthodontic (braces) ☐ Periodontal (Gums) ☐ Root Canal

15 Are you satisfied with your teeth? Specify ______	☐	☐

Thank You