MEADOWOOD DENTAL CENTRE

7-200 Meadowood Drive
Winnipeg MB R2M 5G3

New Patient Form

PATIENT INFORMATION

Name _____ Sex F ❑ M ❑

Address _____

City/Prov. _____ Postal Code _____

Home # _____ Business # _____ Cell # _____

Birth Date _____ (mm/dd/yyyy) Employer _____ Occupation _____

In case of emergency who should be notified? _____ Relationship _____

Emergency Phone Numbers: Work # _____ Home # _____

Parent/Guardian/Caregiver 1 Information

Name (Surname, Given): _____ Relationship _____

Address _____ Phone # _____

City/Prov. _____ Postal Code _____

Employer _____ Occupation _____ Work # _____

Parent/Guardian/Caregiver 2 Information

Name (Surname, Given): _____ Relationship _____

Address _____ Phone # _____

City/Prov. _____ Postal Code _____

Employer _____ Occupation _____ Work # _____

Person financially responsible for account (if different from patient) _____

Relationship to patient _____ Is patient covered by insurance? Y ❑ N ❑

Are you likely to be available on short notice for future appointments or changes? Y ❑ N ❑

We would like to send you appointment reminders/confirmations. Would you prefer to be contacted by:

Phone ❑ Text ❑ Email ❑ Text & Email ❑ Email _____

We would like to send you communications which may include newsletters, upcoming events, and important notifications. Check the box if you would like to receive future email and text communications from us. ❑

PLEASE COMPLETE THIS SECTION IF YOU ARE COVERED BY INSURANCE

INSURANCE

The following information is necessary for proper insurance coverage:

Subscriber name _____

Subscriber date of birth _____ (mm/dd/yyyy)

Insurance company _____ Employer _____

Group/Plan # _____ Subscriber ID# _____

PLEASE COMPLETE THIS SECTION IF YOU HAVE MORE THAN 1 INSURANCE COMPANY:

Second subscriber name _____ Date of birth _____ (mm/dd/yyyy)

Insurance company _____ Employer _____

Group/Plan # _____ Subscriber ID# _____

MEDICAL HISTORY

Physician's name _____ Phone # _____

Date of last visit _____ (mm/dd/yyyy) Have you been hospitalized in the last year? Y ❑ N ❑

Describe _____

Do you chew or smoke tobacco? Y ❑ N ❑

Women: Are you pregnant? Y ❑ N ❑ Due Date _____ (mm/dd/yyyy) Nursing? Y ❑ N ❑

Taking birth control? Y ❑ N ❑

Are you currently taking any medications, blood thinners, drugs, pills or herbal supplements? Y ❑ N ❑

If so please list and describe all below:

	Name of medication, drug or supplement	**Condition taken for**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ARE YOU ALLERGIC TO OR HAVE YOU REACTED TO ANY MEDICATION OR LATEX? Y ❑ N ❑

If so please list and describe all below:

	Drug name	**Reaction**
1.		
2.		
3.		
4.		

Do you have any other allergies? Y ❑ N ❑ Do you carry an epipen? Y ❑ N ❑

If yes, please explain: _____

Do you have or have you ever had a pacemaker, a replacement or a repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Y ❑ N ❑

If yes, please explain: _____

Have you been advised to take antibiotic pre-medication prior to dental treatment? Y ❑ N ❑

If yes, please explain: _____

Do you have a prosthetic or artificial joint? Y ❑ N ❑

If yes, please provide details: _____

Do you have any conditions or have undergone therapies that could affect your immune system? Y ❑ N ❑
(Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy, steroid therapy)

If yes, please explain: _____

MEDICAL HISTORY

Have you had hepatitis, jaundice, liver disease, or gastrointestinal disorders? Y ❑ N ❑

If yes, please explain: _____

Do you have a bleeding problem, bleeding disorder or bruising tendency? Y ❑ N ❑

If yes, please explain: _____

Do you have any or have you ever had any of the following (check all that apply):

❑ High Blood pressure
❑ Diabetes
❑ Cancer
❑ Heart Disease
❑ Heart Attack
❑ Chest pain/Angina
❑ Stroke
❑ Heart Murmur
❑ Other _____

❑ Rheumatic Fever
❑ Lung Disease
❑ Asthma
❑ Shortness of breath
❑ Fainting/dizzy spells
❑ Seizures/Epilepsy
❑ Parkinsons disease
❑ Thyroid disease

❑ Kidney disease
❑ Arthritis
❑ Stomach ulcers
❑ Mental disorder
❑ Alzheimers/Dementia
❑ Eating disorder
❑ Tuberculosis
❑ Drug, Alcohol or Cannabis use

❑ Sexually transmitted disease

Additional comments: _____

PATIENT DENTAL HISTORY

Reason for today's visit: _____

_____

Do you have a dental problem that needs to be addressed as soon as possible? Y ❑ N ❑

Have you been visiting the dentist regulary? Y ❑ N ❑

Date of last... dental visit _____ (mm/dd/yyyy) Cleaning _____ (mm/dd/yyyy) Full mouth x-rays _____ (mm/dd/yyyy)

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Are your teeth sensitive to... Hot ❑ Cold ❑ Biting ❑ Sweets ❑ Sour ❑ N/A ❑

Do your gums bleed regularly? Y ❑ N ❑

Does your jaw crack, click or pop when opened widely? Y ❑ N ❑

Have you noticed any loosening/movement of your teeth? Y ❑ N ❑

Have you had periodontal (gum) treatment? Y ❑ N ❑

Have you had orthodontic (braces) treatment? Y ❑ N ❑

Have you had an unusual reaction to dental freezing? Y ❑ N ❑

Do you experience dental anxiety/nervousness during dental visits? Y ❑ N ❑

Please list any other information that you feel we should have to provide you with the best possible dental care:

_____

_____

REFERRAL

How did you here about us?

Referral (family, friend or colleague ❑ Internet ❑ Health Care Professional ❑ Emergency/Walk-in ❑

Other ❑ _____

TAKE NOTE

OFFICE POLICY

Your appointment time will be reserved for you. If you are unable to keep the appointments, we will require **48 hours notice**, otherwise it my be necessary to charge for the time lost.

FOR OFFICE USE ONLY

Notes and comments:

ADDENDUMS

1. _____

_____ _____

Signature of patient or guardian Date mm/dd/yyyy

2. _____

_____ _____

Signature of patient or guardian Date mm/dd/yyyy

3. _____

_____ _____

Signature of patient or guardian Date mm/dd/yyyy

AUTHORIZATION

AUTHORIZATION: ALL PATIENTS OR GUARDIANS MUST SIGN

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I understand that I am financially responsible for all charges **whether or not** paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits, while maintaining compliance with privacy legislation. I authorize the use of this signature on all insurance. I authorize release of information in my electronic claim submission to my insurance company plan administration. I understand that you require a full 48hrs notice to change/cancel appointments to avoid a possible short notice cancellation or missed appointment fee.

_____ _____

Signature of patient or guardian Today's date mm/dd/yyyy