Ayr Dental

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The following information is required by the dentist to assist in proper diagnosis and treatment.
All information is confidential.

PERSONAL INFORMATION (please print)

Name: ____
Last First

Address: ____
Street City Postal Code

Phone No: ____________ Sex: ______ Marital Status: ____________ Birth Date: ___|___|___
D M Y

Cell: ______________________ Email: ______________________

Employed by: ______________________ Phone No: ______________ Ext:________

Dental Insurance: ☐ Yes ☐ No Insurance Company: ______________________

Cert No.: ______________________ Group (policy) No.: ______________________

Whom may we thank for referring you?: ______________________

Reason for today's visit: ______________________

In case of emergency please notify: Name: ______________________

Relationship: ______________________ Phone No: ______________________

Physician: ______________________ Phone No: ______________________

MEDICAL HISTORY

1. Date of last physical examination: ______________________
2. Have you ever had a serious illness or taken prolonged medication?........ ☐ Yes ☐ No
3. Have you ever been hospitalized?........ ☐ Yes ☐ No
4. Are you presently under the care of a physician?........ ☐ Yes ☐ No
   Please explain: ______________________
5. Are you presently taking any medication?........ ☐ Yes ☐ No
   Please list: ______________________
6. Have you ever experienced any unusual reaction to any drugs? ____________ ☐ Yes ☐ No
   (Please circle) Local anaesthetic, penicillin, aspirin, codeine, other ____________
7. Do you have any allergic conditions? (e.g. Hay fever, asthma rash, other) ____________ ☐ Yes ☐ No
   Please list: ______________________
8. Do you bruise easily or have prolonged bleeding?........ ☐ Yes ☐ No
9. Do you experience shortness of breath, chest pains or swollen ankles?........ ☐ Yes ☐ No
10. Have you gained or lost excessive weight?........ ☐ Yes ☐ No
11. Have you had radiation therapy?........ ☐ Yes ☐ No
12. Do you smoke?........ ☐ Yes ☐ No Do you drink alcohol?........ ☐ Yes ☐ No
13. Have you ever had or currently have any of the following?

☐ High blood pressure	☐ Heart trouble	☐ Jaundice	☐ Liver trouble	☐ Cancer	☐ AIDS
☐ Heart attack	☐ Blood Problems	☐ Hepatitis A/B	☐ Tuberculosis	☐ Arthritis	☐ Depression
☐ Heart murmur	☐ Immune problems	☐ Nervous disease	☐ Stomach problems	☐ Stroke	☐ Anxiety
☐ Rheumatic fever	☐ Thyroid problems	☐ Venereal disease	☐ Intestinal problems	☐ Diabetes	☐ Eating disorder

14. Is there any history of family disease?____________ ☐ Yes ☐ No
15. Are you pregnant or planning a pregnancy?........ ☐ Yes ☐ No
16. Do you have any disease or condition not listed above? ____________ ☐ Yes ☐ No
    Please list: ______________________

DENTAL HISTORY

1. How frequently do you see the dentist? ☐ 6 months ☐ yearly ☐ other Last dental visit? ____________
2. Have you been given oral hygiene instruction in? ☐ brushing ☐ flossing ☐ other ____________
3. Are your teeth sensitive to: ☐ cold ☐ sweets ☐ heat ☐ other ____________
4. Do your gums bleed when: ☐ brushing ☐ flossing ☐ spontaneously
5. Do you grind or clench your teeth? .... ☐ Yes ☐ No

1. What are you looking for in a dental office? ____________
2. Have you had a bad dental experience? ____________
3. What do you dislike about going to the dental office? ____________
4. Can you come to the office AM/PM/EVE./SAT., anytime, short notice? ____________

FINANCIAL RESPONSIBILITY

Unless otherwise arranged, payment for services is requested on the day the treatment in rendered.

INSURANCE

In order to prevent misunderstanding about dental insurance we wist our patients to know that all professional services are CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS ON THE DAY treatment is provided. We will prepare necessary reports to help collect your benefits from insurance companies. However, each fee is individual and may vary with different cases, therefore, collection of benefits may vary slightly.

Person responsible for account: ____________

Payment is accepted by ☐ Visa ☐ M.C. ☐ CØ ☐ Financial Arrangement

CONSENT

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 local anaesthetic as indicated and I will assume full responsibility for fees associated with those procedures

Patient (Parent, Guardian) Signature ____________

IF PARENT/GUARDIAN. PLEASE PRINT NAME____________

OFFICE USE ____________

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