Creekside
DENTAL CENTRE

Professional and Caring Dentistry Serving Kemptville and Beyond
709 Rideau St, P.O. Box 1150, Kemptville, ON K0G 1J0 613-258-9889

PATIENT INFORMATION

Patient Name: ______________________________
Last First Initial

Preferred Name: ______________________________

Birth Date: ____/____/____
Month Day Year

○ Married ○ Single ○ Child ○ Other
○ Male ○ Female ○ Other

Phone: Home:____________ Work:____________

Address:____________________ ________
Street Apt#

____________ ________ ____________
City Province Postal Code

HEALTH INFORMATION

1. **Have you ever had any of the following? Please check those that apply:**

○ AIDS or HIV
○ Anemia
○ Angina
○ Anxiety
○ Arthritis
○ Artificial Joints ________ Type
○ Asthma
○ Autism/Spectrum Disorders ________ Type
○ Blood Disease

○ Cancer ________ Type/Date
○ Chemotherapy ________ Date
○ Diabetes ________ Type
○ Drug Dependancy
○ Epilepsy/Seizures
○ Excessive Bleeding
○ Fainting/Dizziness
○ Glaucoma
○ Head Injuries
○ Heart Attack ________ Date

○ Hepatitis
○ Heart Disease
○ Heart Valve Problems
○ Heart Murmur
○ High Blood Pressure
○ Kidney Disease
○ Latex Allergy
○ Liver Disease
○ Pacemaker
○ Penicillin Allergy

○ Psychiatric Treatment
○ Radiation Therapy ________ Date
○ Respiratory Problems
○ Rheumatic Fever
○ Sinus Problems
○ Stomach Problems
○ Stroke ________ Date
○ Thyroid Disease
○ Tuberculosis
○ Tumors
○ Ulcers

○ Other, not listed ______________________________

2. Do you have any other allergies not listed above? ○ No ○ Yes ____________ List of other allergies
3. Do you smoke or chew tobacco? ○ No ○ Yes
4. Has your medical doctor advised you to take antibiotics before dental treatment? ○ No ○ Yes
5. Have you ever had complications following dental treatment? ○ No ○ Yes
6. Have you been admitted to hospital requiring emergency care in the last 2 years? ○ No ○ Yes
7. Women only: Are you pregnant? ○ No ○ Yes
8. Do you have any further health concerns that should be noted? ○ No ○ Yes
   If yes, please list: ______________________________
9. Name of Medical Doctor and Phone Number: ______________________________
10. Name of Pharmacy and Phone Number: ______________________________

MEDICATION LIST

Name	Dose	Time of day	Reason for use	Length of time

INSURANCE INFORMATION

PRIMARY		SECONDARY	
NAME OF SUBSCRIBER	DATE OF BIRTH	NAME OF SUBSCRIBER	DATE OF BIRTH
EMPLOYER		EMPLOYER	
INSURANCE COMPANY		INSURANCE COMPANY	
GROUP/POLICY #	I.D/CERTIFICATE #	GROUP/POLICY #	I.D/CERTIFICATE #

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

◯ Website ◯ Another patient/friend ◯ Relative ◯ Dental Office ◯ Yellow Pages

◯ Newspaper ◯ Brochure ◯ Work ◯ Other ___________________________________

CONSENT AND RELEASE (to be completed at appointment time)

I, the undersigned, state the I have provided an accurate and complete medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/ Dental history and I consent to my physician and/or insurance company being contacted and provided with information, if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anesthetic and amalgam as may be necessary. I also understand that I assume responsibility for any and all fees associated with services provided to me or my dependents. I am aware that missed or canceled appointments without 24 hours notice will be invoiced to my account in the amount of $25.00.

Patient (Parent/Guardian) Signature: ___________________________________ Date: __________________

If Parent, Guardian, please print name:____