Please fill in this form digitally or manually.
See page 2 for filling instructions.

Creekside DENTAL CENTRE

Professional and Caring Dentistry Serving Kemptville and Beyond

2868 Cty Rd 43, Unit 7, RR1 Kemptville, ON K0G 1J0 • 613-258-9889

PATIENT INFORMATION

Patient Name: ____
Last First Initial

Birth Date: _____/_____/_______ Married Single Child Other
Month Day Year Male Female

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:**

HIV or AIDS	Chemotherapy	Heart Disease	Radiation Therapy
Anemia	Diabetes	Heart Valve Problems	Respiratory Problems
Angina	Drug Dependancy	Heart Murmur	Rheumatic Fever
Anxiety	Epilepsy/Seizures	High Blood Pressure	Sinus Problems
Arthritis	Excessive Bleeding	Kidney Disease	Stomach Problems
Artificial Joints	Fainting/Dizziness	Latex Allergy	Stroke
Asthma	Glaucoma	Liver Disease	Thyroid Disease
Blood Disease	Head Injuries	Pacemaker	Tuberculosis
Cancer	Heart Attack	Penicillin Allergy	Tumors
	Hepatitis	Psychiatric Treatment	Ulcers

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

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

You may complete this form in 2 ways – digitally, or print out and manually fill.

Digital:

1. Save the file on your computer as YourName_Creekside Client Form.pdf
2. Type in the information requested. *Note: you will be asked to sign the form on the day of your appointment*
3. Send the file by email to info@creeksidedentalcentre.ca

Manual:

1. Print the pdf
2. Fill in the information requested (please print), and sign
3. Bring the printed form with you to your first appointment