608 Bloor Street West
Toronto / ON / M6G 1K4

TELL US ABOUT YOURSELF

Last Name _____First Name _____Middle Initial ____

Gender by which/if you identify _____

Are You ------ Single Married Common Law A Child Other

Date of Birth (MONTH/DAY/YEAR) m_____ d_____ y_____

Mailing Address _____

Postal Code _____ _____

Phone Numbers we may reach you at

(H)_____ (W)_____ (C)_____

Primary Email Address _____

Whom may we thank for referring you to NOWsmile Dentistry?

Internet Search	Sign Outside	Website/Social Media	Newspaper/Magazine
Dental Office Referral	A Friend	Colleague	Other_____

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PRIMARY INSURANCE INFORMATION

Name of Insured_____

Insured's Date Of Birth (month/day/year) _____/_____/_____

Insured's Address_____

Insured's Employer Name_____

Employer Address_____

Client's Relationship to Insured: Self Spouse/Partner Child

Insurance Plan Name_____

Insurance Address_____

ID#_____ Group#_____

SECONDARY INSURANCE INFORMATION

Name of Insured_____

Insured's Date Of Birth (month/day/year)_____/_____/_____

Insured's Address_____

Insured's Employer Name_____

Employer Address_____

Client's Relationship to Insured: Self Spouse/Partner Child

Insurance Plan Name_____

Insurance Address_____

ID#_____ Group#_____

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MEDICAL HISTORY

The following information is required by NOWsmile Dentistry so that we may provide you with the best possible dental care. All information is strictly private and is protected by dental professional-client confidentiality. The dentist, hygienist or denturist will review these questions and any others you may have and explain any information that you do not understand.

When was your last medical check-up? _____

What is your physician's name, address and phone number?

_____

Are you currently taking any medications, non-prescription drugs or herbal supplements of any kind? Yes No

If yes, please list_____

_____

Are you being treated for any medical condition at the present time or within the past year? Yes No

If yes, please explain _____

Do you have any allergies? Yes No

If yes, please explain _____

Have you ever had an adverse reaction to any medications or injections? Yes No

If yes, please explain _____

Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? Yes No

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Do you have a prosthetic or artificial joint? Yes No

Have you ever been prescribed antibiotics prior to any dental treatment?

Yes No

Do you have any bleeding problems or bleeding disorders?

Yes No

If yes, please explain _____

Do you have or have you ever had any of the following? (*Please circle*)

Chest Pain	Angina	Heart Attack	Stroke	Prosthesis
Pacemaker	Lung Disease	Tuberculosis	Cancer	Radiation Therapy
Jaundice	Asthma	Diabetes	Arthritis	Epilepsy
Kidney Disease	Thyroid Disease	Liver Disease	Drug/Alcohol dependency	Hepatitis A B C
Multiple Sclerosis	Stomach Ulcers	Vision Impairment	Sinus Problems	Hearing Disability
Mental or Nervous Disorder	High Blood Pressure	Low Blood Pressure	Anxiety/ Depression	HIV or AIDS

Are there any conditions **not listed above** that you have or have had in the past?

Please explain_____

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Do you have any family history of disease? Yes No

If yes, please explain _____

Have you ever been hospitalized? Yes No

If yes, please explain _____

Are you breast-feeding or pregnant? Yes No

DENTAL HISTORY

How may we help you today? _____

When was your last visit to the dentist? _____

What was done on your last visit? _____

What is your current or former dentist's name, address and phone number? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you smoke or use smoking products? Yes No

If yes, how frequently? _____

Do your gums bleed when you brush or floss? Yes No

Are your teeth sensitive to hot or cold? Yes No

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Are you currently experiencing any dental pain? Yes No

Do you grind or clench your teeth at NIGHT or during the DAY? Yes No

Have you had dental surgery of any kind? Yes No

If yes, please explain _____

Have you ever had orthodontic treatment (braces)? Yes No

Do you currently have any dental implants, partials or dentures? Yes No

If yes, please explain _____

Are you interested in whitening your smile? Yes No

IN CASE OF EMERGENCY whom may we contact?

_____

Relationship to client _____

Contact numbers (H)_____ (C) _____

To the best of my knowledge all of the preceding information is correct. If I ever have a change in my health, I will inform NOWsmile Dentistry at my next appointment without fail. _____ (*Client's Initials*)

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AUTHORIZATION AND CONSENT

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I authorize the diagnosis of my dental health by means of study models, photographs, radiographs or other diagnostic aids deemed appropriate. I authorize the dental professional to release any information, including the diagnosis and records of treatment/examinations for myself and my dependent(s), to third-party insurance carriers, payers and/or healthcare practitioners.

Clients who carry dental insurance understand that all dental services are charged directly to the client and that he/she is personally responsible for payment of all services rendered. NOWsmile Dentistry will help prepare the client's insurance forms and assist in making collections from insurance companies. Our clinic cannot render services on the assumption that the resulting charges will be covered by insurance.

I understand that I am financially responsible for any balance for services on the day of the appointment. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of Client, Parent or Guardian

X_____

Date_____

Signature of Dental Professional

X_____

Date_____