Last Name: _____ First Name: _____

Mailing Address: _____

City: _____ Province: _____ Postal Code: _____

Marital Status M S D W Date of Birth: _____/_____/_____ Age:_____ Gender: _____
(Please circle one) M D YYYY

Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email Address: _____

Who should we call in case of an Emergency Name_____
Phone Number: _____ Relationship to patient: _____

How did you hear about our office? Road Sign / Internet search / Staff Member / Patient Referral
Family Member / Live in the area / Other
If by referral, who referred you_____

Pharmacy: _____ Phone Number: _____

Family Physician: _____ Phone Number: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: _____ Plan Holder Name: _____

Policy Number: _____ Certificate/ ID Number: _____

Employer: _____ Occupation: _____

Secondary Insurance Company (if available): _____ Plan Holder Name: _____

Date of Birth:____/_____/_____Policy Number: _____Certificate/ ID Number: _____
M D YYYY

Please note: Insurance companies do not inform us of changes to your plan. You must inform us if changes are made, especially with regard to recall visits. Your insurance policy is a contract between you, your employer and the insurance company. As dental care providers our financial relationship is with you, the patient, not your insurance company. The financial responsibility for your treatment is yours whether the insurance company pays or not.
As a courtesy to our patients who have dental coverage, we will happily send your claim electronically. Your deductible and co-payment are due on the date of service

I have read the payment information carefully and understand that I am responsible for all procedures that I consent to.
Privacy Policy: I am aware that BEAMSVILLE SMILES has a detailed Privacy Policy for the office and dental practice and that I may ask to view it any time. I understand that personal information will not be shared with anyone not listed in the Privacy Policy unless permission is obtained first.

beamsville smiles
FAMILY DENTISTRY

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand.

Please circle any of the following which you have had or have currently:

Alcohol or Drug abuse
Anemia or Hemophilia
Arthritis
Artificial Heart Valve/Joints
Asthma
Cancer or Tumor
Chemotherapy
Cold Sores
High Cholesterol
Diabetes
Epilepsy or Seizures
Fainting of Dizzy Spells
Heart Murmur
Heart Problems
Hepatitis
High blood pressure
Kidney Disease
Osteoporosis
Latex Allergy
Liver Disease
HIV or Aids
Radiation Therapy
Respiratory Disease
Rheumatic Fever
Sinus Problems
Thyroid Disease

Other medical Conditions (not listed above): _____
_____

Physician's name:_____ Phone Number:_____
Have you been under the care of a specialist during the last two years: YES NO
If yes, for what reason? _____

Have you ever been told you need to be pre-medicated prior to dental work? YES NO

Are you currently taking any natural supplements, prescription or over-the-counter drugs? YES NO

If yes, please list all supplements/medications and dosage:
_____
_____
Do you have any allergies to any medications? _____
Any other known allergies? _____

Do you currently use a form of tobacco? YES NO How much per day? _____

Are you currently using marijuana either medicinally or recreationally? YES NO

Women Only: Are you, or do you think you may be pregnant? YES NO Due Date: _____
Are you currently nursing an infant? YES NO

Signature:_ _____ Date: : _____/_____/_____
M D YYYY

Dental History Form

Are you currently experiencing any dental problems? _____
When was your last dental visit? (Recall/Xrays)? _____

Have you been seeing a dentist regularly?	Y	N
Are there any growths or sore spots in your mouth?	Y	N
Have you noticed any loose teeth, or have any of your teeth shifted?	Y	N
Does food get caught between your teeth?	Y	N
Are your teeth sensitive to heat, cold, sweets or pressure?	Y	N

How often do you use dental floss, proxabrush or stimudents? _____
How often do you brush your teeth? _____
Have you ever had any of the following? (please circle those that apply)

Periodontal treatment/surgery	Orthodontic Treatment
Night Guard/Occlusal Guard	Bite adjustment or teeth ground
Oral Surgery (surgery in mouth or jaw joint)	Implant placement

Are you nervous during dental treatment?	Y	N
Are you happy with the appearance of your teeth?	Y	N

If 'NO', what would you like to see changed? _____

Have you ever had a bad dental experience? Any complications during or following dental treatment? Or do you have any questions or concerns?

_____

_____

The information above is accurate and completed to the best of my knowledge. I agree to inform the team at BEAMSVILE SMILES of any changes in my medical condition. I agree that no employee at BEAMSVILLE SMILES shall be held responsible for any error or omission that may have been made in the completion of my medical and dental information.

Patient Name:_____ Signature:_____