UPPERGAGE
DENTAL CENTRE
www.uppergagedental.ca

Today's Date: _____

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.
Thank you!

Name: _____ Gender ☐ F ☐ M ☐ X

Address: _____

City: _____ Prov.: _____ Postal Code: _____

Birth Date: Day_____Month_____Year_____☐ Single ☐ Married ☐ Widowed ☐ Minor

Contact Preference: ☐ Home ☐ Cell ☐ Text ☐ Email ☐ Work

Home #: _____ Bus.#: _____

Cell #: _____E-mail:_____

Who can we thank for referring you: _____

EMERGENCY INFORMATION

Emerg. Contact: _____ Relationship: _____

Phone: _____

INSURANCE INFORMATION

☐ No Insurance Coverage (I will be responsible for all charges)

☐ I have dental coverage **PLEASE PROVIDE CARD**

☐ I have Secondary dental coverage

DENTAL HISTORY

Date of your last hygiene visit_____ /_____ /_____

How do you feel your overall dental health is:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Rate how regularly you have had your teeth cleaned:
☐ 9 months ☐ 6 months ☐ 3 months ☐ Unknown

How do you feel about the look of your teeth:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is your level of sensitivity to dental procedures:
☐ Low ☐ Moderate ☐ High

Are you interested in having regular hygiene cleanings? ☐ yes ☐ no

Have you ever been treated for TMJ or TMJD? ☐ yes ☐ no

What is the reason for your visit today? _____

MEDICAL HISTORY

Name of Physician: _____ OHIP # _____

Address: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Have you had any serious health problems in the last five years? ☐ yes ☐ no If yes, please explain:

_____

MEDICAL HISTORY (cont'd)

Do you smoke/vape? □ yes □ no □ quit
(For Women) Are you currently pregnant? □ yes □ no
Have you ever needed an antibiotic before a dental appointment? □ yes □ no

Please list prescription/supplemental medications: _____

_____

_____

_____

_____

Please check if you're allergic to any of the following

□ Local anesthetics
□ Penicillin/other antibiotics
□ Barbiturates, sedatives
□ Sulfa drugs
□ Aspirin
□ Shellfish, iodine or red wine
□ Codeine/other narcotics
□ Latex sensitivity
□ Other

Do you have, or have you had, any of the following?

□ AIDS/HIV Positive
□ Alzheimer's Disease
□ Anaphylaxis
□ Arthritis/Gout
□ Artificial Heart Valve
□ Artificial Joint
□ Asthma
□ Blood Disease
□ Blood Transfusion
□ Breathing Problem
□ Bruise Easily
□ Cancer
□ Chemotherapy
□ Chest Pains
□ Cold Sores/Fever
□ Congenital Heart
□ Convulsions
□ Cortisone Medicine
□ Diabetes
□ Drug Addiction
□ Easily Winded
□ Emphysema
□ Epilepsy or Seizures
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/Dizziness
□ Frequent Cough
□ Frequent Diarrhea
□ Frequent Headaches
□ Genital Herpes
□ Glaucoma
□ Hay Fever
□ Heart Attack/Failure
□ Heart Murmur
□ Heart Pace Maker
□ Heart Trouble/Disease
□ Hemophilia
□ Hepatitis A
□ Hepatitis B or C
□ Herpes
□ High Blood Pressure
□ Hives or Rash
□ Hypoglycemia
□ Irregular Heartbeat
□ Kidney Problems
□ Leukemia
□ Liver Disease
□ Low Blood Pressure
□ Lung Disease
□ Mitral Valve Prolapse
□ Pain in Jaw Joints
□ Parathyroid Disease
□ Psychiatric Care
□ Radiation Treatments
□ Recent Weight Loss
□ Renal Dialysis
□ Rheumatic Fever
□ Rheumatism
□ Scarlet Fever
□ Shingles
□ Sickle Cell Disease
□ Sinus Trouble
□ Spina Bifida
□ Stomach/Intestinal
□ Stroke
□ Swelling of Limbs
□ Thyroid Disease
□ Tonsillitis
□ Tuberculosis
□ Tumors or Growths
□ Ulcers
□ Venereal Disease
□ Yellow Jaundice
□ Depression
□ Anxiety Disorders

Have you ever had any serious illness/condition not listed above? If yes, please explain: _____

_____

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of information relating to this claim. I also authorize payment of dental benefits, otherwise payable to me, to be paid directly to Upper Gage Dental Centre.
I agree that Upper Gage Dental Centre can collect, use and disclose personal health information about myself as set out in the information about the office privacy's policies.

Signature _____ Date_____