PLEASE PRINT CLEARLY

Male ________
Female ______

Name ____ Birthdate ____________________

Home Tel______________________ Cell _______________ Office ____________________

Address ____

Occupation___________________________ Employer ____________________________

Referred By ____

Parent or Guardian____

Email Address____

Do You Have Dental Insurance Coverage? Yes_________ No__________

1. PERSONAL INFORMATION *(Please Print)*

Date ____/____/____ (D M Y)

Name: ❑ Mr. ❑ Mrs. ❑ Ms ❑ Miss ❑ Dr. ______________ (GIVEN NAME) ______________ (FAMILY NAME)

Address: ______ (NUMBER) ______ (STREET) ______ (APT)

______ (CITY) ______ (PROV) ______ (POSTAL CODE) Place of Birth ______________

Date of Birth: ____/____/____ (D M Y) Height ______________ Weight ______________

Telephone: Residence ______________ Business ______________ Ext. ________

Occupation: ______________ Place of Business: ______________

Referred by: ______________

Person responsible for account: ❑ Self ❑ Other ______________

Dental Insurance: Yes ❑ No ❑ If Yes, Insurance Name ______________

S.I.N. ______________ Group (Policy) No. ______________

Driver's License ______________

Physician: Name ______________ Telephone ______________

In case of emergency please notify: Name ______________

Relationship ______________ Telephone ______________

2. MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment. All information is confidential.

1. Are you presently under the care of a physician? .... YES ❑ NO ❑
2. Have you ever been hospitalized? .... YES ❑ NO ❑
   Specify: ______________
3. Do you have a heart or circulatory problem of any kind? .... YES ❑ NO ❑
   Specify: ______________
4. Have you ever had rheumatic fever? .... YES ❑ NO ❑
5. Do you have any allergies? .... YES ❑ NO ❑
   Specify: ....
6. Are you presently taking any kind of medication? .... YES ❑ NO ❑
   Specify: A) Drug ________ Reason ________
   B) Drug ________ Reason ________
   C) Drug ________ Reason ________
7. Do you have a bleeding problem? .... YES ❑ NO ❑
8. Are you pregnant? .... YES ❑ NO ❑
9. Have you ever had a reaction to any kind of medicine? .... YES ❑ NO ❑
   Specify: ______________

10. Do you presently have or have you ever had:

Anaemia ❑	Hemorrhage ❑	Rheumatism ❑
Arthritis ❑	High (Low) blood pressure ❑	Scarlet fever ❑
Asthma ❑	Hyper (Hypo) glycemia ❑	Stomach (Intestinal) ulcer ❑
Blood disorder ❑	Kidney disease ❑	Stroke ❑
Cancer ❑	Liver disease (i.e. Hepatitis) ❑	Thyroid problem ❑
Diabetes ❑	Lung disease ❑	Tuberculosis ❑
Epilepsy ❑	Mental or nervous disorder ❑	Venereal disease ❑
Hay Fever ❑	Migraine headaches ❑	AIDS ❑

11. Have you ever had a concussion? .... YES ❑ NO ❑
12. Have you ever fainted? .... YES ❑ NO ❑
13. Have you ever had any illness not included above? .... YES ❑ NO ❑
    Specify: ______________
    Medical Update ______________

3. DENTAL HISTORY

1. How frequently do you see your dentist?
   6 Months ❑ Yearly ❑ Other ________ Last dental visit ________
2. Have you ever been given oral hygiene instruction in:
   Brushing ❑ Flossing ❑ Other ________
3. Have you ever had local anaesthetic? .... YES ❑ NO ❑
   Any complications: ______________
4. Are any of your teeth sensitive to:
   Cold ❑ Sweets ❑ Heat ❑ Other ________
5. Do your gums bleed when: Brushing ❑ Flossing ❑ Spontaneously ❑
6. Do your gums feel swollen or tender? .... YES ❑ NO ❑
7. Do you catch food between your teeth? .... YES ❑ NO ❑
8. Are you aware of any loose teeth? .... YES ❑ NO ❑
9. Have you ever had a full mouth series of dental x-rays? .... YES ❑ NO ❑
10. Does your jaw crack, pop or grate when you open widely? .... YES ❑ NO ❑
11. Do you grind or clench your teeth? .... YES ❑ NO ❑
    Dental Update ______________

PATIENT CERTIFICATION AND APPROVAL

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

Patient (Parent, Guardian) Signature ______________ Date ________

PATIENT (GUARDIAN) CONSENT (FOR MINORS)

I, the undersigned ______________ consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for fees associated with these procedures.

Parent (Guardian) Signature ______________ Date ________

DENTAL

1090 Don Mills Rd, Suite 610
Don Mills, Ontario

(416) 444-2281

WELCOME!!

Welcome to Donway Dental! We are very excited to have you join our amazing dental family. We strive to provide you with the best dental care and taking care of your beautiful smile.

In order to assist us with providing impeccable services, we ask that you please review our cancellation policy below, keeping in mind that when we schedule an appointment for you, we reserve this time for both you as well as our wonderful providers. This time is very valuable to both our team as well as our patients. Please be sure that you understand our cancellation policy and kindly adhere to it.

Should you have any questions, please do not hesitate to ask one of our team members as we are more than happy to assist you.

Thank you for trusting our team with your smile, and we look forward to a long lasting and great dental experience with Donway Dental!

CANCELLATION POLICY:

1. In order to accommodate any change to an existing appointment, as per our office policy, we require a minimum of 48 hours notice to avoid a charge of $40 per half hour of any scheduled visit.
2. Please note, that we do not accept cancellations VIA voice mail, in the event that an appointment needs to be rescheduled or cancelled, we request that you kindly call during regular office hours and speak directly to one of our team members and we would be happy to find an alternative appointment for you.

By signing below, you are acknowledging that you have read and fully understand our cancellation policy.

Patient Name: ____________________________ Date: __________________________

Patient Signature: ___________________________ Witness: _______________________

SMILE ANALYSIS

PLEASE MARK AN X BY ANY STATEMENT YOU AGREE WITH:

____ I WISH MY TEETH WERE WHITER.

____ I THINK SOME OF MY TEETH ARE TOO SMALL.

____ I THINK SOME OF MY TEETH ARE TOO LARGE.

____ I WISH MY TEETH WERE STRAIGHTER.

____ MY GUMS SHOW TOO MUCH WHEN I SMILE.

____ I THINK THERE IS TOO MUCH SPACE BETWEEN SOME OF MY TEETH.

____ BECAUSE I AM NOT TOTALLY PLEASED WITH MY SMILE, I SOMETIMES HESITATE TO SMILE.

____ I HAVE OFTEN WISHED I COULD CHANGE SOME OF THE FEATURES OF MY SMILE.

____ I AM CONCERNED OVER WHAT THE END RESULT MIGHT LOOK LIKE IF I CHANGE MY SMILE.

____ I AM CONCERNED ABOUT THE COSTS RELATED TO ENHANCING MY SMILE.

____ I KNOW I NEED TO DO A BETTER JOB PROTECTING THE HEALTH OF MY SMILE.

____ I AM NOT REALLY SURE ABOUT ALL OF THE OPTIONS AVAILABLE TO ENHANCE MY SMILE.

____ I HAVE MISSING TEETH THAT I WOULD LIKE REPLACED.

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD IT BE?________

____

NAME: ______________________________________ DATE: ____________________