Sage Creek
DENTAL CENTRE

PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name:_____ Date of Birth:_____ Sex: _____ Age: _____

Home Address:_____ City:_____ Prov:_____ Code:_____

Billing Address (if different):_____ City:_____ Prov:_____ Code:_____

Home Phone:_____ Cell:_____ Email:_____

Employer/Occupation:_____ Bus. Phone:_____

Spouse's Name & Phone:_____ DOB:_____

Primary Dental Insurance:_____ Group #:_____ ID#:_____

Secondary Dental Insurance:_____ Group #:_____ ID#:_____

Subscriber's Name:_____

DENTAL INFORMATION

Reason for today's visit: ☐ Exam ☐ Consultation ☐ Emergency ☐ Other

Date of Last Dental Visit: _____

☐ Cosmetic questions or concerns	☐ Broken/chipped filling/tooth	☐ Sensitive to hot/cold/sweets
☐ Discomfort, clicking or popping jaw	☐ Teeth clenching/grinding	☐ Red, swollen or bleeding gums
☐ Sensitivity when biting	☐ Bad Breath	☐ Periodontal Disease (Gum Disease)

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

Have you had instructions for the proper methods of brushing and flossing? ☐ Yes ☐ No

HEALTH INFORMATION

• Family Physician:_____ Phone #:_____

• Are you now under the regular care of a physician? ☐ Yes ☐ No

If yes, please explain and provide dates:_____

_____

• Have you had any major operations, hospitalization or illnesses? ☐ Yes ☐ No

If yes, please explain and provide dates:_____

_____

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain and provide dates:_____

_____

• Do you smoke? ☐ Yes ☐ No How Much/Day?:_____

Please list any medications, including over the counter, and herbal supplements you are taking: ☐ None

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

PTO

Have you ever had an allergic reaction to any of the following? Please check those that apply: ☐ No

☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Clindamycin ☐ Cipro ☐ Dental Anesthetics ☐ Latex

Have you ever had any of the following? Please check those that apply: ☐No known conditions

☐ Allergies:

_____

_____

☐ Anemia

☐ Bleeding Disorder

☐ Blood Thinner

☐ Hay Fever

☐ Sinus problems

☐ Asthma

☐ Emphysema

☐ Tuberculosis

☐ Respiratory problems

☐ Heart Murmur/MVP

☐ Rheumatic fever

☐ Congential Heart Defect

☐ Artificial Heart Valves

☐ Heart Attack

☐ Heart Surgery

☐ Pacemaker

☐ High Blood Pressure

☐ Low Blood Pressure

☐ Stroke

☐ Diabetes Type1 Type2

☐ Cancer

☐ Radiation/Chemo

☐ Growths/Tumors

☐ Ulcers

☐ Acid Reflux

☐ Stomach Problems

☐ Colitis

☐ Liver Disease

☐ Hepatitis ☐A ☐B ☐C

☐ Jaundice

☐ Kidney Problems

☐ Seizures

☐ Epilepsy

☐ Fainting Spells

☐ Thyroid Disorder

☐ Back Problems

☐ Arthritis

☐ Artificial Joints

☐ Bisphosphonate Use

☐ Multiple Sclerosis

☐ Fibromyalgia

☐ Glaucoma

☐ Migraines

☐ Head Injuries

☐ ADD/ADHD

☐ Mental Disorders

☐ Alcohol Abuse

☐ Recreational Drug Use

☐ STD:

If YES, Please specify:

_____

_____

☐ HIV/AIDS

Female Patients Only:

Are you pregnant? ☐Yes ☐No

Are you nursing? ☐Yes ☐No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____

Signature of patient, parent or guardian

FINANCIAL AGREEMENT

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy. **ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE.** If a procedure requires multiple appointments, payment is required in full at the first appointment.

Payment Options:

1. Cash
2. Debit
3. MasterCard
4. Visa

Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash or credit card authorization).

Parents accompanying their child are financially responsible for payment.

Records can be viewed at any time. There is a nominal charge for release or copies of records.

BECAUSE INSTRUMENTS, CHAIRS, AND PERSONNEL ARE RESERVED EXCLUSIVELY FOR YOUR APPOINTMENT, THERE IS A *$102.30 CHARGE FOR CHANGED OR BROKEN APPOINTMENTS LESS THAN 2 BUSINESS DAYS IN ADVANCE.

I,_____, agree to these financial terms.

Signature:_____ Date:_____

Subject to change.