R U SMILING DENTAL

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New Patient Form

DATE

Please print clearly in blue or black ink, and tick every box that applies.

01 PATIENT INFORMATION

LEGAL FIRST NAME

MIDDLE NAME

LAST NAME

PREFERRED NAME

DATE OF BIRTH

GENDER

☐ Male ☐ Female ☐ Other

IF OTHER, PLEASE SPECIFY

MOBILE PHONE

HOME OR WORK PHONE (OPTIONAL)

EMAIL

ADDRESS

APARTMENT OR UNIT

CITY

PROVINCE

POSTAL CODE

EMERGENCY CONTACT

NAME

RELATIONSHIP TO PATIENT

DAYTIME PHONE

HEALTH-CARE PROVIDERS

Do you have a family doctor or primary health-care provider? ☐ Yes ☐ No

FAMILY DOCTOR OR PRIMARY HEALTH-CARE PROVIDER

PHONE OR ADDRESS

MEDICAL SPECIALISTS

Do you see any medical specialists? ☐ Yes ☐ No

If yes, use one row for each specialist.

SPECIALIST	SPECIALTY	PHONE OR ADDRESS

02 GENERAL MEDICAL HISTORY

Please answer every question. Your information is confidential and helps us provide safe dental care.

Are you currently being treated for a medical condition, or have you been treated within the past year? ☐ Yes ☐ No

IF YES, THE CONDITION

IF YES, THE PROVIDER

IF YES, THE CURRENT TREATMENT

WHEN WAS YOUR LAST MEDICAL CHECKUP? (DATE OR APPROXIMATE DATE)

Has your general health changed during the past year? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN

Are you taking any prescription medication, non-prescription medication, vitamins or herbal supplements? ☐ Yes ☐ No

MEDICATIONS

If yes, list every prescription medication, non-prescription medication, vitamin and herbal supplement you take.

MEDICATION	DOSE	FREQUENCY	REASON

Do you have any allergies? ☐ Yes ☐ No

ALLERGIES

If yes, list each one. Tick the category on the row, or write it beside the substance.

SUBSTANCE	REACTION	SEVERITY

CATEGORY ☐ Medications ☐ Latex or rubber ☐ Environmental or seasonal ☐ Food or other

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✧ Have you ever had an unusual or adverse reaction to a medication, injection or local anesthetic? ☐ Yes ☐ No

IF YES, THE MEDICATION OR INJECTION, AND THE REACTION

✧ Do you have, or have you ever had, asthma? ☐ Yes ☐ No

IF YES, SEVERITY

IF YES, TRIGGERS

IF YES, INHALER

IF YES, PREVIOUS HOSPITALIZATION

✧ Do you have, or have you ever had, heart or blood-pressure problems? ☐ Yes ☐ No

IF YES, THE CONDITION AND ITS CURRENT STATUS

Have you had a replacement or repaired heart valve, infective endocarditis, congenital heart disease or a heart transplant? ☐ Yes ☐ No

IF YES, DETAILS

Do you have a prosthetic or artificial joint? ☐ Yes ☐ No

IF YES, WHICH JOINT

IF YES, SURGERY DATE

IF YES, SURGEON

Do you have a condition or treatment that affects your immune system, including HIV, leukemia, chemotherapy, radiotherapy or transplant medication? ☐ Yes ☐ No

IF YES, DETAILS

Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No

IF YES, THE TYPE AND CURRENT STATUS

Do you have a bleeding disorder, unusual bruising or prolonged bleeding? ☐ Yes ☐ No

IF YES, DETAILS

Are you taking aspirin, anticoagulants or other medications that affect bleeding? ☐ Yes ☐ No

IF YES, MEDICATION

IF YES, DOSE

IF YES, PRESCRIBING PROVIDER

Have you ever been hospitalized for an illness or operation? ☐ Yes ☐ No

IF YES, THE REASON

IF YES, APPROXIMATE DATE

03 CONDITIONS AND ADDITIONAL INFORMATION

Do you have or have you ever had any of the following? Please check every one that applies, or check None.

CARDIOVASCULAR

- ☐ None
- ☐ Heart Attack/Myocardial Infarction
- ☐ Heart Murmur
- ☐ Congestive Heart Failure
- ☐ Pacemaker/Defibrillator
- ☐ Rheumatic Fever
- ☐ Other (specify)
- ☐ High Blood Pressure
- ☐ Angina (Chest Pain)
- ☐ Mitral Valve Prolapse
- ☐ Irregular Heartbeat (Arrhythmia)
- ☐ Stroke or Transient Ischemic Attack (TIA)
- ☐ High Cholesterol

IF YOU TICKED ANYTHING MARKED (SPECIFY), PLEASE GIVE DETAILS

RESPIRATORY

- ☐ None
- ☐ Lung Disease
- ☐ Chronic Bronchitis
- ☐ Sleep Apnea/CPAP use
- ☐ Persistent Cough
- ☐ Other (specify)
- ☐ Asthma
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Emphysema
- ☐ Tuberculosis (current or past)
- ☐ Shortness of Breath

IF YOU TICKED ANYTHING MARKED (SPECIFY), PLEASE GIVE DETAILS

ENDOCRINE, METABOLIC & RENAL

- [ ] None
- [ ] Diabetes Type I
- [ ] Diabetes Type II
- [ ] Thyroid Disease (Hyper or Hypothyroid)
- [ ] Adrenal Disorder
- [ ] Steroid Therapy (Prednisone, Cortisone)
- [ ] Osteoporosis
- [ ] Osteoporosis Medications (e.g. Fosamax, Actonel)
- [ ] Kidney Disease
- [ ] Obesity
- [ ] Other (specify)

IF YOU TICKED ANYTHING MARKED (SPECIFY), PLEASE GIVE DETAILS

GASTROINTESTINAL

- [ ] None
- [ ] Acid Reflux/GERD
- [ ] Ulcers
- [ ] Irritable Bowel Syndrome (IBS)
- [ ] Crohn's Disease/Ulcerative Colitis
- [ ] Hepatitis (A, B, C, other)
- [ ] Liver Disease
- [ ] Other (specify)

IF YOU TICKED ANYTHING MARKED (SPECIFY), PLEASE GIVE DETAILS

NEUROLOGICAL

- [ ] None
- [ ] Epilepsy/Seizures
- [ ] Migraine Headaches
- [ ] Multiple Sclerosis
- [ ] Parkinson's Disease
- [ ] Alzheimer's or Dementia
- [ ] Nerve Damage
- [ ] Anxiety Disorder
- [ ] Depression
- [ ] Other (specify)

IF YOU TICKED ANYTHING MARKED (SPECIFY), PLEASE GIVE DETAILS

HEMATOLOGIC & IMMUNE

- [ ] None
- [ ] Anemia
- [ ] Bleeding Disorders
- [ ] Blood Clots / Deep Vein Thrombosis
- [ ] HIV/AIDS
- [ ] Autoimmune Disease (Lupus, RA, etc.)
- [ ] Cancer (current or past — specify type)
- [ ] Organ Transplant

- [ ] Other (specify)

IF YOU TICKED ANYTHING MARKED (SPECIFY), PLEASE GIVE DETAILS

MUSCULOSKELETAL

- [ ] None
- [ ] Joint Replacement (specify)
- [ ] Temporomandibular Joint Disorder (TMJ)
- [ ] Other (specify)
- [ ] Arthritis (Rheumatoid or Osteoarthritis)
- [ ] Chronic Back Pain
- [ ] Fibromyalgia

IF YOU TICKED ANYTHING MARKED (SPECIFY), PLEASE GIVE DETAILS

OTHER

- [ ] None
- [ ] Any other condition or disease (specify)
- [ ] Drug, Alcohol or Cannabis Use or Dependency

IF YOU TICKED ANYTHING MARKED (SPECIFY), PLEASE GIVE DETAILS

ADDITIONAL QUESTIONS

Do any significant medical conditions run in your family, such as diabetes, cancer or heart disease? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN

Do you smoke, vape or chew tobacco or nicotine products? ☐ Yes ☐ No

IF YES, TYPE, AMOUNT AND FREQUENCY

Are you nervous or anxious during dental treatment? ☐ Yes ☐ No

IF YES, HOW CAN WE MAKE YOU MORE COMFORTABLE?

Are you currently pregnant? ☐ Yes ☐ No ☐ Not applicable

IF YES, EXPECTED DELIVERY DATE

Are you currently breastfeeding? ☐ Yes ☐ No ☐ Not applicable

Are you using birth control? ☐ Yes ☐ No ☐ Not applicable

Have you reached menopause? ☐ Yes ☐ No ☐ Not applicable

Do you identify as a person with a disability or as Deaf, or require an accommodation? ☐ Yes ☐ No

IF YES, HOW MAY WE ASSIST YOU?

ANYTHING ELSE THE DENTIST SHOULD KNOW

Is there anything else the dentist should know about your health?

☐ Nothing else to report

04 DENTAL HISTORY AND INSURANCE

WHAT IS THE REASON FOR TODAY'S VISIT? ARE YOU EXPERIENCING A DENTAL PROBLEM?

Have you been seeing a dentist regularly? ☐ Yes ☐ No

IF NO, THE REASON

WHEN WAS YOUR LAST DENTAL VISIT, AND WHAT WAS DONE? ("NEVER" AND "I'M NOT SURE" ARE ANSWERS TOO)

WHEN WERE YOUR LAST DENTAL X-RAYS TAKEN? ("NEVER" AND "I'M NOT SURE" ARE ANSWERS TOO)

Have you previously seen a dental specialist? ☐ Yes ☐ No

IF YES, TYPE OF SPECIALIST

Have you had a bad experience or complication during dental treatment? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN

Have you been instructed to take antibiotics before dental appointments? ☐ Yes ☐ No

IF YES, THE REASON

IF YES, THE MEDICATION

HOW OFTEN DO YOU BRUSH?

☐ Once daily ☐ Twice daily ☐ Occasionally ☐ Never

HOW OFTEN DO YOU FLOSS OR USE ANOTHER INTERDENTAL CLEANER?

☐ Once daily ☐ Twice daily ☐ Occasionally ☐ Never

Do your gums bleed when brushing or flossing? ☐ Yes ☐ No

Do you have jaw pain, clicking or restricted movement? ☐ Yes ☐ No

Have you injured your teeth or jaws, including in a motor-vehicle accident? ☐ Yes ☐ No

Do you have concerns about bad breath or the appearance of your teeth? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN

PRIMARY INSURANCE

Do you have dental insurance? ☐ Yes ☐ No

If yes, please complete the boxes below.

INSURANCE COMPANY

POLICY HOLDER

POLICY HOLDER'S DATE OF BIRTH

RELATIONSHIP TO PATIENT

ID OR CERTIFICATE NUMBER

GROUP OR PLAN NUMBER

SECONDARY INSURANCE

Do you have secondary insurance? ☐ Yes ☐ No

If yes, please complete the boxes below.

INSURANCE COMPANY

POLICY HOLDER

POLICY HOLDER'S DATE OF BIRTH

RELATIONSHIP TO PATIENT

ID OR CERTIFICATE NUMBER

GROUP OR PLAN NUMBER

PERSON OR AGENCY RESPONSIBLE FOR PAYMENT

05 POLICIES, CONSENT AND SIGNATURE

Appointments

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. Our Office Policy states that patients must give us 1 business day notice if they cannot keep an appointment time. Appointment changes with less than 1 business day notice are subject to a service fee based on the amount of time that was allocated and reserved for you.

Payment

Payment in full is due the day of treatment, or upon the start of major treatment. Dental Insurance Plans often pay less than the actual fee for service; should a patient have dental insurance with assignment to R U Smiling Dental, the estimated patient portion will be the amount due the day of treatment. For your convenience, we accept Cash, Debit, Visa, Mastercard. The patient is responsible for any amount not covered by their plan.

Examination and Information Authorization

I consent to an initial dental examination by the dentists and authorized oral-health providers at R U Smiling Dental.

I authorize the practice to use and disclose relevant dental and medical information to insurers and other health-care providers for payment, referral and continuity-of-care purposes, as permitted by law.

This authorization does not replace the informed-consent discussion required for any proposed treatment or procedure.

I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed. I authorize and request my insurance company to pay my benefits directly to providers of R U Smiling Dental.

☐ I have read and accept the office policies and authorizations above.

PATIENT CERTIFICATION

I certify that the medical and dental information I provided is accurate and complete to the best of my knowledge.

I understand that this information is important for safe care, and I agree to notify R U Smiling Dental about future changes in my health, allergies or medications.

Please read the above, then enter your Full Name and sign below. Your signature is recorded on the date of this form submission.

☐ Yes, I accept

PATIENT/PARENT/GUARDIAN/SUBSTITUTE DECISION-MAKER NAME

RELATIONSHIP TO PATIENT, IF APPLICABLE

SIGNATURE

DATE

06 FOR OFFICE USE ONLY

Left blank by the patient. This record is not to be treated as reviewed until the treating dentist has signed and dated below.

MEDICAL ALERT: CRITICAL ALLERGIES AND SIGNIFICANT CONDITIONS

FOLLOW-UP QUESTIONS AND CLINICAL NOTES

CONSULTATIONS OR TREATMENT MODIFICATIONS

TREATING DENTIST'S NAME

DENTIST'S SIGNATURE/INITIALS

DATE REVIEWED

END OF FORM