In order to submit this form, you should open it with Adobe Acrobat Reader.

Arbutus Broadway Dental Centre
*A commitment to excellence*

# WELCOME TO OUR OFFICE

Please complete the following questionnaire as proper treatment requires that we become acquainted with each patients vital information. All questions answered within are **strictly confidential**. Please feel free to contact reception for clarification or help.

## PERSONAL HISTORY

**Name** *

First Name Last Name

**Date of Birth** *

Month Day Year

**Gender**

- ☐ Male
- ☐ Female
- ☐ Trans
- ☐ Other

**Preferred Name**

**How did you hear about us?**

**Preferred Phone Number** *

**Phone Type** *

**Alt Phone Number**

**Phone Type**

**Email** *

example@example.com

**Preferred Contact Method** *

**Address** *

Street Address

City

Postal Code

**Emergency Contact** *

First Name Last Name

**Emergency Contact Phone Number** *

**Are you available in the future for short notice appointments?** *



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○ No

## DENTAL INSURANCE & DENTAL SERVICE PAYMENT

Patient's payment will be due in full at the time treatment is rendered. We will assist patients with reimbursement from their insurance. If you have any questions or concerns regarding insurance please contact our office.

## APPOINTMENTS

To assist us with our daily scheduling we request that you give us **48 hours notice for appointment changes. Your appointment time is reserved for you and a fee for short cancellations and missed appointments may apply.**

## DENTAL INSURANCE

**Primary Dental Insurance Carrier**

**Name of Insured**

**Group/Policy Number**

**Date of Birth of Insured**

**ID/Certificate Number**

**Employer/Plan Type**

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**Secondary Dental Insurance Carrier**

**Name of Insured**

**Group/Policy Number**

**Date of Birth of Insured**

**ID/Certificate Number**

**Employer/Plan Type**

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## DENTAL HISTORY

**Former Dentist** *

**Phone Number**

**Date of last dental visit** *

**Do your gums bleed?** *

- Yes
- No

**Do you use a rinse?** *

- Yes
- No

**How often do you brush your teeth?** *

**Do you have any dental concerns at present?**

**How often do you floss?** *

## MEDICAL HISTORY

**Physician's Name** *

**Physicians Phone Number**

**Are you allergic to any medications? If yes which?** *

**Have you been examined or treated by a physician recently?** *

- Yes
- No

**What medications or non prescription drugs are you taking now?** *

**Do you require antibiotic coverage prior to dental treatment?** *

- Yes
- No



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Please check if you've have or had any of the following:

- ☐ Heart murmur
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Hepatitis
- ☐ Heart Problems
- ☐ Angina ( Chest Pain)
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Smoker?
- ☐ Artificial valves, joints
- ☐ Asthma/ breathing problems
- ☐ Infections/communicable dieases
- ☐ Contact sensitivity (latex, paba)
- ☐ Sinus trouble (hay fever)

**Women Only: Are you Pregnant? How many months?**

**Taking Oral Contraceptives?**

- ○ Yes
- ○ No

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**Do you have any other health concerns the doctor should know about?**

**I consent to photography for record keeping and promotional purposes of**

- ☐ Teeth, mouth, jaw and face
- ☐ Teeth, mouth and jaw
- ☐ I do not consent to photography

CONSENT FOR TREATMENT

This is to certify that I, the undersigned, concent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including use of local anaesthetic as indicated. I fully understand the office policy and I will assume responsibility for fees associated with those procedures performed.

**Signature**

**Parent or guardian signature**



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