PATIENT CONTACT: ALL INFORMATION IS STRICTLY CONFIDENTIAL

PERSONAL INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Dr. Other: ______________________

NAME ______________________ Today's Date ______________________

DATE OF BIRTH ______________________ AGE ______________________

By what name do you prefer to be addressed? ______________________ ☐ male ☐ female

If under 18 years, name of parent or guardian ______________________

ADDRESS ______________________

CITY ______________________ PROVINCE __________ POSTAL CODE ______________________

HOME PHONE ______________________ WORK PHONE ______________________

CELL PHONE ______________________ EMAIL ______________________

OCCUPATION ______________________ ☐ STUDENT

EMPLOYER OR SCHOOL: ______________________

Emergency contact name & phone:

Physicians name & phone:

Whom may we thank for referring you? ______________________

INSURANCE INFORMATION ☐ No dental insurance

Name of Insurance Company ______________________

Group Policy/Plan No. ______________________ Division/Section No. ______________________

Company/Employer ______________________

Subscriber's/Plan Member's Name ______________________

Subscriber ID/Certificate No./ID No./S.I.N. ______________________

Subscriber's/Plan Member's Date of Birth ______________________

Relationship to Subscriber/Plan Member ______________________

SECONDARY INSURANCE INFORMATION ______________________

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For EDI Submissions:
I authorize my dental office to submit my family's dental insurance claims electronically. I authorize release, to my dental benefits plan administrator, of information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revokes the same.

Signature: ______________________

Thank you for coming in. We value your patronage.

Dr. M. Tanen ●Telephone 905-889-2181●www.drtanen.com

NEW PATIENT MEDICAL HISTORY: ALL INFORMATION IS STRICTLY CONFIDENTIAL

NAME ______________________________ Today's Date ______________________

AGE __________

	Please check (☑)	Yes	No
Are you allergic to or have had an adverse reaction to any medications or injections?		❑	❑
If yes, please specify: ______________________			
Are you allergic to or have had an adverse reaction to latex/rubber products or to any foods?		❑	❑
If yes, please specify: ______________________			
Are you taking any prescription or non-prescription medications?		❑	❑
If yes, please list names, dosages & condition: ______________________			
Do you smoke?		❑	❑
If yes, how much? ______________________			
Women: Are you pregnant or nursing?		❑	❑
If pregnant, what is the expected delivery date? __________			
1. Have you had any immunocompromising condition or treatment such as leukemia or chemotherapy?		❑	❑
2. Do you have a heart murmur or mitral valve prolapse?		❑	❑
3. Have you ever had rheumatic fever or infective endocarditis?		❑	❑
4. Do you have a pacemaker or prosthetic heart valve?		❑	❑
5. Do you have a prosthetic or artificial joint?		❑	❑
6. Do you have a bleeding problem or disorder or any heart or blood pressure problems?		❑	❑

If you answered yes to any of questions 1-6 above, please give details: ______________________

Do you have or have you ever had any of the following? **Please check (☑)**

❑asthma ❑stroke ❑heart attack ❑angina ❑arthritis ❑diabetes
❑mental/nervous disorder ❑stomach ulcers ❑kidney disease ❑drug/alcohol dependency ❑organ transplant
❑memory issues ❑ Alzheimer's/dementia ❑cancer ❑ herpes/cold sores ❑HIV

If you checked any of the boxes above, please give details: ______________________

Please list past hospitalizations and serious illnesses or conditions: ______________________

Is there anything else about yourself that the dentist should be made aware of? ______________________

SIGNATURE (Patient) ______________________

Dentist's Notes: