

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 (and pronoun) do you prefer to be addressed? _____

male female X

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. _____

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 _____

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 (Patient): _____

Thank you for coming in. We value your patronage.
Dr. M. Tanen ●Telephone 905-889-2181●www.dratanen.com

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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: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to or have had an adverse reaction to latex/rubber products or to any foods? If yes, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any prescription or non-prescription medications? If yes, please list names, dosages & condition: _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? If yes, how much? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Women: Are you pregnant or nursing? If pregnant, what is the expected delivery date? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Have you had any immunocompromising condition or treatment such as leukemia or chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a heart murmur or mitral valve prolapse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had rheumatic fever or infective endocarditis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a pacemaker or prosthetic heart valve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have a prosthetic or artificial joint?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have a bleeding problem or disorder or any heart or blood pressure problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

<input type="checkbox"/> asthma	<input type="checkbox"/> stroke	<input type="checkbox"/> heart attack	<input type="checkbox"/> angina	<input type="checkbox"/> arthritis	<input type="checkbox"/> diabetes
<input type="checkbox"/> mental/nervous disorder	<input type="checkbox"/> stomach ulcers	<input type="checkbox"/> kidney disease	<input type="checkbox"/> drug/alcohol dependency	<input type="checkbox"/> organ transplant	
<input type="checkbox"/> memory issues	<input type="checkbox"/> Alzheimer's/dementia	<input type="checkbox"/> cancer	<input type="checkbox"/> herpes/cold sores	<input type="checkbox"/> 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:
