Welcome to tappuni DENTAL

PATIENT INFORMATION

First Name: ___________________________ Last Name: ________________________ Preferred Name: ____________________
Date of Birth: ________________________ (DD/MM/YY) □Single □Married □Other
Home Address: ____ Apt/Unit#:____________________
City: ____ Province:___________ Postal Code: __________________________
Home phone: ________________________ Cell phone: ____________________ Work phone: ___________________________
E-mail: ____ Best way to contact you: ______________________
Employer: ___________________________________ Occupation: ____
In case of an emergency – Please notify____________________________________ Phone:_____________________
How did you hear about us/ Whom may we thank for referring you? ____

INSURANCE INFORMATION

□ I do not have insurance.
Primary Insurance Company: ___________________________________ Employer's name: ___________________________
Policy Holder's name: ____Date of Birth: ___________________________ (DD/MM/YY)
Policy Holder: □Self □Parent/Guardian □Other _______________ Contact Number: ________________________
Group Policy/Plan Number: __________________________ I.D./Certificate Number: ________________________________

Secondary Insurance Company: _________________________________ Employer's name: ___________________________
Policy Holder's name: ____Date of Birth: ___________________________ (DD/MM/YY)
Policy Holder: □Self □Parent/Guardian □Other _______________ Contact Number: ________________________
Group Policy/Plan Number: __________________________ I.D./Certificate Number: ________________________________

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Tappuni Dental all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____

MEDICAL HISTORY

Do you have or have you ever had any of the following:

□ AIDS or HIV	□ Diabetes	□ High blood pressure	□ Respiratory Problems
□ Allergies ________	□ Drug/alcohol dependency	□ High cholesterol	□ Rheumatic/ scarlet fever
□ Anemia	□ Emphysema	□ Jaundice	□ Seizures
□ Arthritis	□ Excessive bleeding	□ Kidney disease	□ Skin rash
□ Artificial joints	□ Fainting/ dizziness	□ Liver disease	□ Snoring/ sleep apnea
□ Asthma	□ Glaucoma	□ Mental disorders	□ Steroid therapy
□ Blood disease	□ Heart attack	□ Mitral valve prolapse	□ Stomach problems
□ Bruise easily	□ Heart condition/ disease	□ Nervousness/ depression	□ Stroke
□ Cancer	□ Heart murmur	□ Osteoporosis medications	□ Thyroid disease
□ Chemotherapy	□ Heart surgery	□ Pacemaker	□ Tuberculosis
□ Chest pain/ angina	□ Hepatitis	□ Radiation	□ Ulcers

Have you ever had an adverse reaction to any of the following :

□ Aspirin	□ Codeine	□ Penicillin	□ Demerol
□ Erythromycin	□ Local anesthetic	□ Sulfa	□ Latex
□ Other ________________________________			

Are you currently under a physician's care? □Yes □No If yes, what for? ___________________________
Have you been treated for any medical conditions in the last year? ___________________________
Have you ever been hospitalized? □Yes □No If yes, what for? ___________________________
Are you taking any medications, non-prescription drugs or supplements? □Yes □No
Please list:___________________________
Do you smoke? □Yes □No If yes, how many per day? _______________ How many years? __________
For women: Are you pregnant? □Yes □No If yes, delivery date: __________ Are you breastfeeding? □Yes □ No
Family Physician's Name: _______________ Physician's Phone Number: _______________

DENTAL HISTORY

Please check any of the following problems that may apply to you:

- □ Sensitivity (hot, cold and/or sweet)
- □ Tooth pain or discomfort while chewing
- □ Headaches, earaches or neck pain
- □ Jaw joint pain (clicking/cracking)
- □ Teeth or fillings breaking
- □ Loose, tipped or shifting teeth
- □ Grinding or clenching teeth
- □ Bleeding, swollen or irritated gums
- □ Bad breath or bad taste in your mouth
- □ Food gets stuck between teeth

Do you have or have you had any of the following:

- □ Full/ partial dentures
- □ Bridges
- □ Mouth guard
- □ Braces
- □ Periodontal (gum) treatments
- □ Dental Implants

Previous Dental History

Date of last dental exam: __________ Last full set of x-rays:__________ Last dental cleaning __________
Name of previous dentist: _______________Phone: __________ Reason for leaving _______________
Have you ever experienced complications with dental procedures? ___________________________
How frequently do you brush? _______________ How frequently do you floss? _______________
Are you nervous about dental treatment? □Yes □No

If you could change your smile, you would...

Make your teeth brighter	□
Make your teeth straighter	□
Close spaces	□
Replace black metal fillings with natural, tooth coloured fillings	□
Repair chipped teeth	□
Replace missing teeth	□
Replace old crowns that don't match	□

One a scale of 1 to 10, with 10 being the highest rating...

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge. If required, I consent to my physician being contacted regarding any specific medical questions. I authorize the dentist and her auxiliary staff to perform necessary diagnostic procedures and treatment as required achieving a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided. I understand that I will be charged a fee for missed or cancelled appointments with less than 2 business days' notice.

Consent for Collection, Use and Disclosure of Personal Information
I agree that Tappuni Dental has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

Date: _______________ Signature: ___________________________