Bridgeland Dental Care
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PATIENT INFORMATION & PRIVACY FORM

Personal Information

○ Mr. ○ Mrs. ○ Ms. ○ Miss ○ Dr.

Patient's Name ______________________

Preferred First Name ______________ Date of Birth DD / MM / YYYY

Parent / Guardian (if under 18) ______________________

Address ______________________

City ______________ Province ______________ Postal Code ______________

Phone (primary) ______________ Work Phone ______________

E-Mail Address ______________________

How did you find out about our office? ______________________

Emergency Contact ______________________

Phone (primary) ______________ Relationship ______________

Medical History

Family Physician ______________ Phone ______________

Pharmacy ______________ Phone ______________

Are you now under the care of a physician? ○ Yes ○ No

If so, what is the condition being treated? ______________________

Are you taking any drug or medicine? ○ Yes ○ No

If so, please list ______________________

Do you have any drug allergies or reactions? ○ Yes ○ No

If so, please list ______________________

Have you ever had abnormal bleeding from previous extractions, surgery or trauma? ○ Yes ○ No

Are you pregnant or might you be pregnant? ○ Yes ○ No

Please check any of the following that you have had:

○ Rheumatic fever or rheumatic heart disease
○ Asthma
○ Congenital heart lesions, blood or clotting disorder
○ Lung breathing disorders
○ Heart trouble, heart attack, high blood pressure or stroke
○ Kidney disease
○ Chest pains or shortness of breath
○ Hepatitis, jaundice or liver
○ Fainting spells or seizures (eg. epilepsy)
○ Nervous disorder
○ Diabetes (diet or insulin controlled)
○ Cancer
○ Endocrine disorder (eg. thyroid disease)
○ AIDS / HIV
○ Gastrointestinal disease (eg. ulcers)
○ Heart murmur
○ Bone, muscle or joint disorder (eg. arthritis)

Do you have any disease or medical problem not listed above? ○ Yes ○ No

If so, please list ______________________

Dental Information

What dental condition concerns you at present? ______________________

Date of last dental visit ______________ Former Dentist ______________

Are you nervous about receiving dental treatment? ○ Yes ○ No

What is the one most important concern to you regarding dentistry? ○ Cost ○ Time ○ Appearance ○ Discomfort

Are you happy with the appearance of your teeth? ○ Very ○ Fairly ○ No

Financial arrangements: ○ Cash ○ Visa ○ MasterCard ○ Debit

*** Please fill out all fields and supply any other applicable information. Although some questions may seem unimportant at the moment, they are vital in case of an emergency.**

Terms and Conditions

Office Policy

Payment is required each time service is rendered. A scheduled appointment is specifically reserved for you. Please be advised, to avoid a $50.00 charge we require two (2) business days notice to change a scheduled appointment.

Patient Approval for Treatment and Fees

I consent to oral and dental procedures agreed to be necessary or advisable and I will assume responsibility for fees associated with those procedures. I agree to pay all amounts not paid by my insurance plan. I further agree to let the dentist know if my medical status or insurance plan changes. I have been advised this office uses digital radiographs and these records will be transferred electronically in the event that I am referred to a specialist. I understand it can not be guaranteed that these transmissions are secure.

I agree with these terms
I certify that the information given here is correct

X ______________________ X ______________

Signature Date