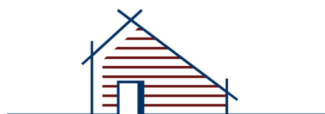

SHELBURNE VILLAGE
DENTAL

Welcome to Shelburne Village Dental, dentistry you can trust.

1. About You

FOR OFFICE USE ONLY: ASA ____________

Today's Date: ____________

Patient's name: ____________ FIRST ____________ LAST ____________ MIDDLE INITIAL

Adult ☐ Child ☐
Male ☐ Female ☐

If child, name of guardian: ____________

I like to be called: ____________

Home address: ____________ STREET ____________ APT. #

____________ CITY/TOWN ____________ PROVINCE ____________ POSTAL CODE

Are other family members patients of our office: Yes ☐ No ☐

If yes, please provide their name(s): ____________

Your employer: ____________ Occupation: ____________

Birthday: ____________ DAY MONTH YEAR

Single ☐ Married ☐ Divorced ☐ Widowed ☐

How did you hear about Shelburne Village Dental? ____________

____

2. Dental Insurance

Do you have dental insurance through your employer: Yes ☐ No ☐

If yes, please provide the following information:

Dental insurance company: ____________

Group/plan #: ____________ Subscriber ID #: ____________

Employer name: ____________

Do you have other dental insurance coverage: Yes ☐ No ☐

If yes, this coverage is through: Spouse ☐ Parent ☐ Other ☐ ____________

Their name: ____________ Their birthday: ____________ DAY MONTH YEAR

Their employer's name: ____________

Dental insurance company: ____________

Group/plan #: ____________ Subscriber ID #: ____________

3. Telephone/Email

Home Tel. #: (   ) ____________ Work Tel. #: (   ) ____________

Cell Tel. #: (   ) ____________ Email: ____________ @ ____________

Can you be reached at work: Yes ☐ No ☐ Best way to contact you? Home ☐ Work ☐ Cell ☐ Email ☐

In the event of an emergency, is there someone who lives near to you that we could contact?

Name: ____________ Relationship: ____________

Home Tel. #: ____________ Work Tel #: ____________

4. Medical History

Family physician's name: ______________________________ Tel. #: ______________________

Approximate date of your last visit: __________________ Your current physical health is: Good ☐ Fair ☐ Poor ☐

Are you currently under the care of a physician? Yes ☐ No ☐ If yes, please explain: ______________________

____

Do you smoke or use tobacco in any other form? Yes ☐ No ☐ Do you require antiobiotic coverage prior to dental treatment? Yes ☐ No ☐

Are you presently taking any drugs prescribed by a physician or dentist? Yes ☐ No ☐

If yes, please list: ____

Have you had any serious medical conditions in the past 5 years? Yes ☐ No ☐ If yes, please explain: ______________________

____

Have you ever had any of the following diseases or medical problems?

			Y N Cancer
Y N Heart Failure	Y N Stroke	Y N Asthma	Y N Chronic Cough
Y N Heart Disease or Attack	Y N Diabetes	Y N Hay Fever	Y N Emphysema
Y N Angina Pectoris	Y N Glaucoma	Y N Allergies or Hives	Y N Multiple Myeloma
Y N Congenital Heart Disease	Y N Arthritis	Y N Sinus Trouble	Y N Radiation Therapy
Y N Heart Murmur	Y N Rheumatism	Y N Ulcers	Y N Chemotherapy
Y N High/Low Blood Pressure	Y N Osteoporosis	Y N Blood Transfusion	Y N Venereal Disease
Y N Arteriostenosis	Y N Cortisone Medicine	Y N Bruise Easily	Y N Malignant Hyperthermia
Y N Mitral Valve Prolapse	Y N Thyroid Disease	Y N Bleeding Problems	Y N Epilepsy or Seizures
Y N Artificial Heart Valve	Y N Kidney Problems	Y N Hemophilia	Y N Developmentally Disabled
Y N Heart Pacemaker	Y N Liver Disease	Y N Anemia	Y N Psychiatric Treatment
Y N Heart Surgery	Y N Paget's Disease	Y N Dental or TMJ Implants	Y N Drug Addiction
Y N Fainting or Dizzy Spells	Y N Hepatitis A, B, C, D, E or F	Y N Artificial Joints (ex. Hip, Knee)	Y N Nervousness
Y N Rheumatic Fever	Y N Tuberculosis (TB)	Y N Cosmetic Surgery	Y N AIDS or HIV Positive

Any other serious medical conditions: ____

Have you experienced any that are not listed above? Yes ☐ No ☐ If yes, please list: ______________________

____

Are you allergic to or have you ever reacted to any of the following?

Y N Aspirin	Y N Percodan	Y N Sleeping Pills	Y N Erythromycin	Y N Metals (ex. Nickel)
Y N Local Anesthetic	Y N Nitrous Oxide	Y N Valium	Y N Tetracycline	Y N Latex
Y N Clindamycin	Y N Darvon	Y N Other Antibiotics	Y N Demerol	
Y N Penicillin	Y N Codeine	Y N Cephalosporins	Y N Sulpha Drugs	

For women: Are you pregnant? Yes ☐ No ☐ Week #: ______________________

1. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
2. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) ______________________'s dental needs.
3. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as required to provide proper care.
4. I agree to the use of local anesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
5. Payment is due in full on date of service with the following payment options: CASH, VISA, MASTERCARD, INTERAC
   Our office is equipped to submit insurance claims electronically if we have your correct information. (Note: Not all insurance companies do electronic claims.)
   PLEASE DO NOT HESITATE TO ASK OUR STAFF SHOULD YOU HAVE ANY QUESTIONS REGARDING PAYMENT.
6. Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it will be necessary to charge for time lost.
7. I authorize release, to my dental benefits plan administrator & the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the name dentist. This authorization will continue in effect until the undersigned revokes the same.

I UNDERSTAND AND AGREE TO THE POLICIES LISTED ABOVE.

Patient's Name: ______________________ Dentist: ______________________

Parent/Guardian's Name: ______________________ Relationship to Patient: ______________________

Signature of Patient, Parent or Guardian: ______________________ Date: ______________________