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MINORU laser dental

changing how you feel about visiting the dentist

1. Please call our office or use our online booking service to schedule your first appointment
2. Complete this form in advance [optional] (type in the fields then either print and sign the document and bring it with you on your first visit or email it to our office to be printed and/or signed at the time of your visit.)

CONFIDENTIAL PATIENT RECORD

PERSONAL INFORMATION

Dr. ☐Mr. ☐Mrs. ☐Ms ☐Miss ☐Other

Name: First _____ *Last* _____

Address _____

City/Province _____ Postal Code _____

Phone: *Residence*( ) _____ *Business*( ) _____

Phone:Cell( ) _____ Date of Birth ___ / ___ / ___ Sex ☐M ☐F

Email: _____

Occupation: _____ Employer: _____

Work Address: _____ City: _____

Spouse's Name: _____ Cell #: _____

Whom may we thank for referring you? _____

In case of emergency, please contact _____ Phone ( ) _____

S.I.N. _____ Drivers License No. _____

Dental Insurance: ☐No ☐Yes Insurance Carrier _____

Dental Policy Numbers _____

How do you wish to pay for your dental services today? ☐Cash ☐Cheque ☐ VISA ☐MasterCard

HEALTH QUESTIONNAIRE

1. Do you have a current medical problem? ☐ No ☐ Yes

   Explain: _____

2. Have you ever been sick from, shown an allergy to or told not to take:

   ☐ *Antibiotics* ☐ *Codeine* ☐ *Aspirin* ☐ *Metals*
   ☐ *Latex* ☐ *Penicillin* ☐ *Novocain*

   Or other dental anesthetic ? ☐ *Other* _____

3. Are you now taking or using medication for:

   ☐ *Diabetes (pills or shots)* ☐ *Nerves (tranquilizers)* ☐ *Arthritis or rheumatism*

   ☐ *Stomach (ulcer, other)* ☐ *Blood (liver/iron pills)* ☐ *Allergies*

   ☐ *Heart or Blood Pressure*

4. *Are you taking a prescription?* ☐ *Yes* ☐ *No* *List:* _____

5. Have you ever been hospitalized for any length of time? ☐ No ☐ Yes

   If Yes List: _____

6. Following injuries, have you ever had bleeding problems? ☐ No ☐Yes

7. Do you experience shortness of breath? ☐ No ☐ Yes

8. Have you heart disease, pain, pressure or tightening in your chest? ☐ No ☐ Yes

9. Have you ever had chemo or radiation therapy? ☐ No ☐ Yes

10. Do you or have you ever had? *Please Check any that apply*

Heart trouble ☐	Diabetes ☐	Blood Disorders ☐	Artificial joints/Heart Valves ☐
High Blood Pressure ☐	Epilepsy ☐	Anaemia ☐	Nervous Problems ☐
Rheumatic Fever ☐	Thyroid trouble ☐	HIV Virus/AIDS ☐	Chest Pain ☐
Kidney trouble ☐	Tuberculosis ☐	Hepatitis ☐	Cancer ☐
Liver trouble ☐	Asthma ☐	Stroke ☐	Sinus Problems ☐

Any others _____

11. For women only: Are you pregnant? ☐ *No* ☐ *Yes*

Physician's Name _____ *Physician's Phone (* ___ *)* _____

DENTAL HISTORY

1. How long since your last dental visit? _____

2. Have you come to this office for relief of pain? ☐ No ☐ Yes

3. Have you had the pain more than three weeks? ☐ No ☐ Yes

4. Do your gums bleed when brushing or flossing your teeth? ☐ No ☐ Yes

5. Are your teeth sensitive to sweets, cold, chewing or hot? ☐ No ☐ Yes

If Yes, Where? _____

6. Does food catch between your teeth? ☐ No ☐ Yes Where? ☐

7. Are you aware of clenching or grinding your teeth? ☐ No ☐ Yes

8. Do you currently experience any popping, clicking or pain in your jaw joints? ☐ No ☐ Yes

9. Do you feel nervous about having dental treatment? ☐ No ☐ Yes

10. Are you satisfied with the appearance of your teeth? ☐ No ☐ Yes

11. Describe what you would like us to do for your teeth? (i.e. what are the reasons you are seeking treatment) ☐

CONSENT FOR TREATMENT

This is to certify that I the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated. I understand and agree that (regardless of my insurance status) I will assume responsibility for the entire balance of my account at the time professional services are rendered. Any accounts not paid in full will carry a billing fee of $25.00 per month.

I have read all the information on this form and have completed the answers to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Patient's (Parent's) Signature _____ Date: ☐

Person responsible for account: ☐