



Vivian Duffy



Dr. Monika Kiepas



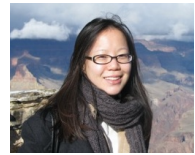
Dr. David Burman



Gina Arancon-Kovesdi



Luiza Kaci



Susan Ching-Ju Yang

PERSONAL INFORMATION

Family Name _____ First Name _____

Date of Birth (dd/mm/yy) _____ Sex: M F

Father's Name _____ Date of Birth (dd/mm/yy) _____

Mother's Name _____ Date of Birth (dd/mm/yy) _____

Street # _____

City _____ Postal code _____

Home phone _____ Business phone: Mother's _____

Father's _____

Who may we thank for referring you? _____

Person to contact in case of emergency:

Name _____ Phone _____

PLEASE REFER TO MEDICAL QUESTIONNAIRE ON NEXT PAGE

MEDICAL HISTORY QUESTIONNAIRE

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please provide as much information as you can.

1. Are you being treated for any medical condition at present or have you been treated within the past year? Yes No Not Sure

Explain _____

2. When was your last medical checkup? _____

3. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? No If yes, please list: _____

4. Do you have any allergies? If you answered yes, please list, using categories below:

Yes No Not Sure

Medications _____

Latex/Rubber Products _____

Other (Hay-fever, foods) _____

5. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. Yes No Not Sure

6. Do you have or have you ever had asthma?

Yes No Not Sure

7. Do you have or have your ever had any heart or blood pressure problem?

Yes No Not Sure

8. Do you have an artificial heart valve?

Yes No Not Sure

9. Do you have a prosthetic or artificial joint?

Yes No Not Sure

10. Have you ever been advised by your doctor to take antibiotics every time you have dental treatment? Yes No Not Sure

11. Do you have any conditions or therapies that could affect your immune system e.g. Leukaemia, AIDS, HIV, radiotherapy, chemotherapy?

Yes No Not Sure

12. Have you ever had hepatitis, jaundice or liver disease?

Yes No Not Sure

13. Do you have a bleeding problem or blood disorder?

Yes No Not Sure

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. Yes No Not Sure

15. Do you have or have you ever had any of the following? Please check:

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Angina | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Steroid Therapy | <input type="checkbox"/> Seizures (Epilepsy) |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lung Disease | |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Prosthetic Heart Valve | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain: Yes No Not Sure

17. Are you nervous during dental treatment?

- Yes No

Name of Family Doctor: _____

Phone #: _____

I authorize my dentist to obtain medical information from my physician(s).

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date _____

PLEASE REFER TO DENTAL QUESTIONNAIRE ON NEXT PAGE

DENTAL QUESTIONNAIRE

Reason for this visit _____

1. Age: _____ years _____ months

2. Last dental visit _____, dental x-rays _____

3. How often does your child usually have dental check-ups? Every:

3-4 months 6 months 9 months less often

4. What kind of toothbrush does your child use?

Manual: hard soft

Electric

5. Does your child use any mouthwash? Yes No

6. How often does your child floss? rarely x a week _____ daily

7. Please choose one of the following:

- I brush my child's teeth
- my child brushes teeth under my supervision
- my child brushes teeth unattended
- I let my child brush and then I brush her/his teeth myself

8. Have your child ever had?

fillings root canal extractions
 head trauma TMJ problem orthodontic treatment

9. Is your child involved in any contact sports? Yes No

10. Does your child wear protective mouthguard? Yes No n/a

11. Does your child have any of the following oral habits?

sucking pacifier sucking fingers biting pens, nails
 grinding teeth at night snoring

12. What does your child usually drink?

tap water bottled water juice pop
 milk chocolate milk

13. How often does your child have sweets?

never _____ x a day _____ x a week

PAYMENT OPTIONS:

VISA, MASTERCARD, DEBIT, CHEQUES and CASH

WE ACCEPT DIRECT PAYMENTS FROM YOUR DENTAL INSURANCE COMPANY UNDER CERTAIN CONDITIONS:

1. We can verify your coverage details.
2. Policy is assignable (payable directly to dentist).
3. You provide us with a credit card to be used for all expenses not covered by your dental insurance.

For your convenience we offer deferred payment plans. Please inquire at front desk.

We use EDI. We do (on your request) submit insurance claims electronically to your insurance provider.

ELECTRONIC COMMUNICATION

We send emails to remind patients about future appointments, book and confirm appointments, verify insurance information. We require your consent to use this form of communication. You can revoke your consent at any time.

Do you consent to receiving electronic communication from Dental Care Centre?

Yes, email address _____ No

Parent/Guardian's signature

Date

DDS' signature

Date

DENTAL CARE CENTRE

Dr. Monika Kiepas & Dr. David Burman

81 St. Clair Avenue East, Toronto, Ontario, M4T 1M7

Phone: (416) 961-8778 Fax: (416) 961-5776