Dental Care Centre
81 St. Clair Avenue East, M4T 1M7 − (416) 961-8778
dcconline@rogers.com

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) _____

Address _____

City _____ Postal code _____

Home phone # _____ Business phone # Father's: _____

Mother'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. What conditions are you taking the medications for? _____

   _____

5. Do you have any allergies? ☐ Yes ☐ No ☐ Not Sure

   If yes, please list, using categories below:

   Medications ☐ _____

   Latex/Rubber Products ☐ _____

   Other (Hay-fever, foods) ☐ _____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections?

   ☐ Yes ☐ No ☐ Not Sure

   If yes, please explain: _____

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

   ☐ Yes ☐ No ☐ Not Sure

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

   ☐ Yes ☐ No ☐ Not Sure

9. Do you have an artificial heart valve?

   ☐ Yes ☐ No ☐ Not Sure

10. Do you have a prosthetic or artificial joint?

    ☐ Yes ☐ No ☐ Not Sure

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

12. Do you have any conditions or therapies that could affect your immune system (e.g. Leukemia, AIDS, HIV, radiotherapy, chemotherapy)?

    ☐ Yes ☐ No ☐ Not Sure

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

☐ Yes ☐ No ☐ Not Sure

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

☐ Yes ☐ No ☐ Not Sure

15. Have you ever been hospitalized for any illnesses or operations?

☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

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

☐ Chest Pain	☐ Angina	☐ Shortness of Breath
☐ Pacemaker	☐ Steroid Therapy	☐ Seizures (Epilepsy)
☐ Drug/Alcohol Dependency	☐ Heart Attack	☐ Arthritis
☐ Kidney Disease	☐ Tuberculosis	☐ Stomach Ulcers
☐ Stroke	☐ Prosthetic Heart Valve	☐ Diabetes
☐ Thyroid Disease	☐ Cancer	

17. Are there any conditions or diseases not listed above that you have or have had?

☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

18. Are you nervous during dental treatment? ☐ Yes ☐ No

Name of Family Physician:

_____

Phone #: _____

Parent's Signature: _____ Date:

_____

Dentist Signature: _____ Date:

_____

PLEASE REFER TO DENTAL QUESTIONNAIRE ON NEXT PAGE

DENTAL QUESTIONNAIRE

1. Reason for this visit: _____
2. Age: _____ years _____ months
3. Last dental visit _____, dental X-rays _____
4. How often does your child usually have dental check-ups? Every:
   ☐ 3-4 months ☐ 6 months ☐ 9 months ☐ less often
5. What kind of toothbrush does your child use?
   Manual: ☐ hard ☐ soft
   Electric ☐
6. Does your use any mouthwash? ☐ Yes ☐ No
7. How often does your child floss? ☐ rarely ☐ _____x a week ☐ daily
8. *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 his/her teeth myself
9. Has your child ever had?
   ☐ fillings ☐ root canal ☐ extractions
   ☐ head trauma ☐ TMJ problem ☐ orthodontic treatment
10. Is your child involved in any contact sports? ☐ Yes ☐ No
11. Does your child wear a protective mouthguard? ☐ Yes ☐ No ☐ N/A
12. Does your child have any of the following oral habits?
    ☐ sucking pacifier ☐ sucking fingers ☐ biting pens, nails
    ☐ grinding teeth at night ☐ snoring
13. What does your child usually drink?
    ☐ tap water ☐ juice ☐ milk
    ☐ bottled water ☐ pop ☐ chocolate milk
14. 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. You agree to cover all charges for procedures not included in your policy.
2. You agree to cover all charges in excess of your policy annual limit.

   (Please note, this is **YOUR** responsibility to track insurance spending)
3. Policy is **assignable** (payable directly to dentist). Please sign below:

   I hereby assign my benefits, payable from claims submitted electronically to Dr. Monika Kiepas and authorize payment directly to her. This authorization shall continue in effective until the undersigned revokes the same.

   Policy holder: _____

   Policy holder's signature: _____

   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.

Parent's Signature: _____ Date: _____

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.

email address: _____

Parent's Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

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