Shoreham Dental
FAMILY DENTAL CARE
TORONTO

4732 Jane Street
Toronto, Ontario M3N 2L2
905-661-6117 ● shorehamdental.ca

PATIENT INFORMATION

Welcome to Our Dental Office

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. Please fill in the entire form.

PERSONAL INFORMATION

☐Dr. ☐Mr. ☐Mrs. ☐Miss ☐Ms
Last Name: ______________________
First Name: ______________________
Mid: __________ Preferred Name: __________
Status: ☐Single ☐Married ☐ Child ☐ Other
Date of Birth (DD/MM/YY): _____/_____/_____
Home Address: ______________________
Apt: ______________________
City: ______________________
Postal Code: ______________________
Email: ______________________
Home Tel: ______________________
Work Tel: ______________________
Cell: ______________________
Employer: ______________________
Occupation: ______________________
Physician: ______________________
Physicians Phone No: ______________________
Previous Dentist: ______________________
Why have you decided to change dental offices? ______________________
How did you hear about us? ______________________

INSURANCE INFORMATION 1

Name of insured if different from above: ______________________
Employer: ______________________
Date of Birth of Insured (DD/MM/YY): _____/_____/_____
Insurance Company: ______________________
Policy/Group: ______________________
Division (If applicable): ______________________
Certificate ID#: ______________________
Do you have Secondary Insurance? ☐ ☐ Yes (Please fill out the next section)

INSURANCE INFORMATION 2

Name of insured if different from above: ______________________
Employer: ______________________
Date of Birth of Insured (DD/MM/YY): _____/_____/_____
Insurance Company: ______________________
Policy/Group: ______________________
Division (If applicable): ______________________
Certificate ID#: ______________________

EMERGENCY CONTACT

Name: ______________________
Relationship: ______________________
Tel: ______________________

MEDICAL HISTORY

	YES	NO
Are you being treated for any medical condition at the present time or have you been treated within the last year?	☐	☐
If yes, specify: ______________________		
When was your last medical check-up? ______________________		
Has there been any change in your general health in the past year?	☐	☐
Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below:	☐	☐

Drug: __________ Reason: __________
Drug: __________ Reason: __________
Drug: __________ Reason: __________
Drug: __________ Reason: __________

SEE REVERSE

	YES	NO
Do you have any allergies? ☐ Latex ☐ Other: ______________________	☐	☐
Have you had an unusual reaction to any drugs or medicines?	☐	☐
☐ Penicillin ☐ Sulfonamide ☐ Aspirin ☐ Codeine ☐ Local Anesthetic ☐ Other: ______________		
Have you ever taken cortisone or steroid medication?	☐	☐
Do you have any sinus problems?	☐	☐
Do you have or have you ever had any heart problems?	☐	☐
Do you have a pacemaker?	☐	☐
Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?	☐	☐
Do you or have you ever had jaundice, hepatitis or liver disease?	☐	☐
Do you have a bleeding problem or bruise easily? Are you on blood thinner?	☐	☐
Do you have any conditions that could affect your immune system ego AIDS, HIV infection, Leukemia etc?	☐	☐
Do you smoke? If yes, how much? ______________________	☐	☐
Have you ever been hospitalized for any serious illnesses or operations?	☐	☐
Do you have any prosthetic or artificial joints?	☐	☐

Do you have or have you ever had any of the following?

☐ Chest Pain/Angina	☐ Heart Attack	☐ High Blood Pressure	☐ Emphysema	☐ Asthma
☐ Epilepsy	☐ Thyroid Disease	☐ Kidney Disease	☐ Cancer	☐ Chemotherapy/Radiation
☐ Psychiatric Disorder	☐ Tuberculosis	☐ Arthritis	☐ Stroke	
☐ Stomach Ulcers	☐ Diabetes	☐ Drug/Alcohol Dependency		

	YES	NO
For females: Are you pregnant or breast feeding?	☐	☐
Any other conditions or problems of which the dentist should be aware of?	☐	☐

If yes, please list: ______________________

DENTAL HISTORY

When was your last dental visit? ______________________

When did you last have dental x-rays? ______________________

How often do you brush your teeth? ______________________

How often do you floss your teeth? ______________________

	YES	NO
Have you been seeing a dentist regularly?	☐	☐
Do any of your teeth ache?	☐	☐
Have you ever been advised to take antibiotics before dental appointments?	☐	☐
Do your gums bleed when you brush?	☐	☐
Do you have any pain when you chew?	☐	☐
Do you feel that you have bad breath?	☐	☐
Have you ever been in a motor vehicle accident or experienced any blows to your jaw?	☐	☐
Have you ever had a dental implant surgery?	☐	☐
If yes, who performed the surgery and when was it done? ______________________		
Are you being followed-up by a dental specialist?	☐	☐

Please list anything else not mentioned above regarding your past dental history: ______________________

GENERAL CONSENT STATEMENT

I certify that I have read, understood and accurately completed the personal, medical and dental histories, to the best of my knowledge, and not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general and local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.
Please email **info@shorehamdental.ca** when completed

______________________	______________	______________________	______________
Signature of Patient	DD/MM/YYYY	Reviewed by Dentist	DD/MM/YYYY