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? ________________________________

	YES	NO
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