PERSONAL & HEALTH INFORMATION

PARKWAY DENTAL | PICKERING DENTAL
General & Specialist Dentistry
T. 416.441.2565 T. 905.837.2322
www.parkwaydental.ca www.pickeringdental.ca
Divisions of Raj Sivendra Dentistry Professional Corporation

PERSONAL INFORMATION

First Name: ______________________ Last Name: ______________________

Gender: ☐ Male ☐ Female

Birth Date: Month __________ Day __________ Year ______

Address: ______________________ Apt. # ______ City __________ Postal Code __________

Home Phone: (   ) ______________________ Cellular Phone: (   ) ______________________

Work Phone: (   ) ______________________ Ext. # ______ ☐ Mine ☐ Spouse's ☐ Mom's ☐ Dad's

Other Phone: (   ) ______________________ Email address: ______________________

I was referred by: ☐ Family/Friend ☐ Walked in ☐ Yellow Pages ☐ Internet ☐ Newspaper

PERSON RESPONSIBLE FOR ACCOUNT

☐ Myself ☐ Spouse ☐ Mom ☐ Dad ☐ Common-Law ☐ Partner

First Name: ______________________ Last Name: ______________________

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Complete the following if address is different from above.

Address: ______________________ Home Phone: (   ) ______________________

Apt. # ______ City: ______________ Postal Code: __________ Cellular Phone: (   ) ______________________

Email: ______________________ Work Phone: (   ) ______________ Ext. # ______

PAYMENT METHOD

☐ Insurance/Benefits Plan ☐ Cash ☐ Cheque ☐ Visa ☐ Mastercard ☐ Amex

ALTERNATE CONTACT PERSON

In case of an emergency, we would like to contact someone with a different address and phone number from yours.

Name: ______________________ Relationship: ______________ Phone: (   ) ______________

PARKWAY DENTAL | PICKERING DENTAL
General & Specialist Dentistry

HEALTH INFORMATION

Physician's Name: ______________________ Phone: ( ) ____________

Have you ever had any of the following diseases or medical problems? Please circle your answer (Yes / Unsure / No).
If "Yes", please specify or list.

Y ? N Heart Problems	Y ? N Sickle Cell Anemia	Y ? N Arthritis
Y ? N Heart Murmur	Y ? N Chest Pain	Y ? N Glaucoma
Y ? N Stroke	Y ? N Lung Problems	Y ? N Diabetes
Y ? N Congenital Heart Defect	Y ? N Difficulty Breathing	Y ? N Stomach Ulcers / Colitis
Y ? N Rheumatic Fever	Y ? N Emphysema	Y ? N Thyroid Problems
Y ? N Pacemaker	Y ? N Bronchitis	Y ? N Epilepsy / Seizures / Fainting
Y ? N Artificial Heart Valves	Y ? N Asthma	Y ? N AIDS (or related diseases)
Y ? N High Blood Pressure	Y ? N Tuberculosis (TB)	Y ? N Cancer
Y ? N Low Blood Pressure	Y ? N Liver Trouble, Hepatitis	Y ? N Chemotherapy / Radiation
Y ? N Anemia	Y ? N Yellow Jaundice	Y ? N Bleeding Problems
Y ? N Hip/Joint Replacement	Y ? N Kidney Problems	Y ? N Headaches, severe/frequent

Y ? N Have you had any other medical problems not listed above? If "Yes", please specify.

Y ? N Are you under the care of a physician?
Y ? N Are you taking any medications now?
Y ? N Have you been told to take antibiotics before dental appointments?
Y ? N Have you been hospitalized in the last 15 years?
Y ? N Have you had any previous surgery?
Y ? N Have you had an elevated temperature under general anaesthesia?
Y ? N *For Females:* Are you pregnant? If "Yes", week #:
Y ? N Have you ever had orthodontics?
Y ? N Do you wear contact lenses?
Y ? N Do you smoke?
Y ? N Are you allergic or sensitive to any medicines or materials? Check off or list.

- ☐ Penicillin ☐ Tetracycline ☐ Clindamycin ☐ Metronidazole
- ☐ Codeine ☐ Erythromycin ☐ Latex ☐ Aspirin
- ☐ Dental Anesthetics

Please list or expand on any item:

INFORMATION, CONSENT & OFFICE POLICIES

I understand that the information I have given is correct to the best of my knowledge. I consent to the performing of dental procedures which have been discussed with me and agreed to be necessary or advisable.

I understand that the payments from my dental benefits may be below the current fees of General Practitioners in Ontario and that I am responsible to the dentist for any portion of the claims not covered by my dental plan. I authorize my insurance claims to be submitted electronically where applicable.

For cash patients, payment is due in full unless prior arrangements have been approved.

We reserve our staff and facilities for you. We kindly ask that you honour your appointment times. Should you need to cancel or change your appointment, we require 2 business days notice, in which case no charge will be made. This will allow us to give the time reserved for you to someone in need.

Thank you for your cooperation.

Signature ______________________ Date ____________

PRIVACY POLICY: All information contained in this form is confidential.