HERITAGE POINTE DENTAL

The information on this form is essential to render the best professional care. We appreciate your co-operation in filling it out carefully so that we will have accurate records. Thank you.

PLEASE PRINT

Last Name	Mr. Mrs. Miss. Ms. Dr.	First Name	Home Phone	Cell Phone

Apt #	Address	City	Province	Postal Code

Date of Birth: (MM/DD/YYYY)	Marital Status	Email Address

Employer	Business Phone Ext.
Occupation	Best Number to Contact You □ Home □ Cell □ Business

Person Responsible for Payment of Account	Home Phone	Cell Phone
Emergency Contact	Home Phone	Cell Phone

INSURANCE INFORMATION

Do you have Dental Insurance Coverage? □ Yes □ No		
Primary Insurance Company Name	Name of Person Insured: Date of Birth:	Relationship to Person Insured □ Self □ Spouse □ Child □ Other _____
Group/Policy Number: Subscriber/Employee ID:	Employer Name:	
Secondary Insurance Company Name	Name of Person Insured: Date of Birth:	Relationship to Person Insured □ Self □ Spouse □ Child □ Other _____
Group/Policy Number: Subscriber/Employee ID:	Employer Name:	

How did you hear about us? Please provide name (if applicable) _____

- ☐ Yellow Pages
- ☐ Location
- ☐ Friend/Relative
- ☐ Patient
- ☐ Website
- ☐ Denturist
- ☐ Dentist
- ☐ Staff Member
- ☐ Other (please specify) _____

MEDICAL HISTORY

Please answer the following questions:

Reason for today's visit: _____

Physician's Name: _____ Phone Number: _____

Do you have or have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV	☐ Excessive Bleeding	☐ Nervous Disorders
☐ Allergies (please specify)	☐ Fainting	☐ Pacemaker
☐ _____	☐ Glaucoma	☐ Penicillin Allergy
☐ Anemia	☐ Hay Fever	☐ Pregnancy
☐ Arthritis	☐ Head Injuries	☐ Radiation Treatment
☐ Artificial Heart Valve	☐ Heart Disease/Heart Attack	☐ Rheumatic Fever
☐ Artificial Joints	☐ Heart Murmur	☐ Rheumatism
☐ Arrhythmia	☐ Hepatitis	☐ Sinus Problems
☐ Asthma	☐ High Blood Pressure	☐ Stomach Problems
☐ Blood Disease	☐ Jaundice	☐ Stroke
☐ Bronchitis	☐ Jaw Pain	☐ Sulfa Allergy
☐ Cancer	☐ Kidney Disease	☐ Tuberculosis
☐ Codeine Allergy	☐ Latex Allergy	☐ Tumors
☐ Diabetes	☐ Liver Disease	☐ Ulcers
☐ Dizziness	☐ Mental Disorders	☐ Venereal Diseases
☐ Epilepsy	☐ Metal Allergy	☐ Other (please specify) _____

Do you smoke cigarettes or cigars? □ Yes □ No. If yes, how often_____

Do you consume recreational drugs or alcohol? □ Yes □ No. If yes, how often_____

List any medications you are presently taking (including medical cannabis): _____
_____

Have you ever had any complications following dental treatment? □ Yes □ No
If yes, please explain: _____
Are you presently undergoing medical treatment? □ Yes □ No
If yes, please explain: _____
Are you currently suffering from diarrhea, a persistent cough or an undiagnosed skin rash? □ Yes □ No

---

This is to certify that I, the undersigned, provided an accurate assessment of my medical status and consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic and/or oral sedation as indicated and I will assume responsibility for the fees associated with these procedures.

I consent to electronic communication (email and/or text messages) with Heritage Pointe Dental. I understand that I may opt out of such communication at any time.

Signature of Patient, Parent, or Guardian: _____Date: _____