RETTER DENTAL CARE

PATIENT INFORMATION

Name _____ (Last / First / Initial) Sex: M ◯ F ◯ Date of Birth _____ (Month / Day / Year) Age: _____

Address _____ City _____ Postal Code _____

Tel.: Home _____ Cell. Phone _____ E-Mail Address _____

Occupation _____ Tel.: Work _____ Ext. _____

Please indicate the best time to contact you for appointments: Any Time ◯ Days Only ◯ Evenings Only ◯ Weekends ◯

Do you have family members or friends that are patients of this office? No ◯ Yes ◯ _____

Referred by _____

In case of an emergency, contact:

Name _____ Relationship _____ Telephone _____

DENTAL INSURANCE (PRIMARY COVERAGE)

Name of Insured _____ (Last / First / Initial)

Date of Birth _____ (Month / Day / Year)

Employer _____

Insurance Company _____

Group or Policy No. _____

Certificate or ID No. _____

DENTAL INSURANCE (ADDITIONAL COVERAGE)

Name of Insured _____ (Last / First / Initial)

Date of Birth _____ (Month / Day / Year)

Employer _____

Insurance Company _____

Group or Policy No. _____

Certificate or ID No. _____

FOR OFFICE USE ONLY:

ELECTRONIC BENEFIT ASSIGNMENT AUTHORIZATION

I authorize release to my insuring company(s) plan administrator(s) the information contained in claims submitted electronically.

I hereby assign my benefits payable from claims submitted electronically to my treating dentist and authorize payment directly to him /her.

Signature of Subscriber Date

CONFIDENTIAL QUESTIONNAIRE

MEDICAL HISTORY

Family Doctor

Telephone Ext.

Weight Height

	Yes	No
1. Are you presently under a doctor's care?	☐	☐
2. Are you presently taking any drug or medication, or have you taken any in the last 6 months? If so, which:	☐	☐
3. Are you presently taking any homeopathic products? If so, which:	☐	☐
4. Have you ever been hospitalized or have you ever had surgical intervention other than dental?	☐	☐
5. Have you ever been diagnosed or treated for cancer?	☐	☐
6. Have you ever had a heart transplant, heart infection, artificial heart valve or heart condition from birth?	☐	☐
7. Do you smoke or chew tobacco products?	☐	☐
8. Do you have any conditions/therapies that could affect your immune system? (e.g. Leukemia, AIDS, Chemo)	☐	☐

9. Have you ever had and/or been treated for:

	Yes	No		Yes	No		Yes	No
Blood Pressure (High/Low)	☐	☐	Venereal Disease	☐	☐	Rheumatic / Scarlet Fever	☐	☐
Digestive Problems	☐	☐	Dizzy Spells or Fainting Spells	☐	☐	Liver Disease (Hepatitis)	☐	☐
Diabetes	☐	☐	Epilepsy	☐	☐	Arthritis	☐	☐
Eye Problems	☐	☐	Nervous Disorders	☐	☐	Back Problems	☐	☐
Asthma	☐	☐	Stomach Ulcers	☐	☐	Artificial Joints or Implants	☐	☐
Frequent Colds or Sinusitis	☐	☐	Hay Fever	☐	☐	AIDS / HIV Positive	☐	☐
Kidney Disease	☐	☐	Earaches	☐	☐	Thyroid Problems	☐	☐
Prolonged Bleeding	☐	☐	Skin Disease	☐	☐	Anemia	☐	☐
Lung Disease	☐	☐	Frequent Headaches	☐	☐	Tuberculosis	☐	☐
Mitral Valve Prolapse	☐	☐	Drug/Alcohol Dependency	☐	☐	Leukemia	☐	☐
Pacemaker	☐	☐	Osteoporosis	☐	☐	Other	☐	☐

10. Are you allergic to or have you ever had reactions to:

	Yes	No		Yes	No
Specific Foods	☐	☐	Sulfa Drugs	☐	☐
Antibiotics (Penicillin)	☐	☐	Aspirin/Codeine	☐	☐
Iodine	☐	☐	Local Anesthetics	☐	☐
Latex (Rubber)	☐	☐	Metals	☐	☐
Sedatives	☐	☐	Flavours (e.g. Mint)	☐	☐
			Other	☐	☐

	Yes	No
11. Have you ever been told not to donate blood?	☐	☐
12. Have you ever taken drugs for osteoporosis or bone cancer? (Aredia, Actonel, Fosamax, etc.)	☐	☐

Women Only:

	Yes	No
13. Are you pregnant or think you are pregnant?	☐	☐
14. Are you presently nursing?	☐	☐
15. Are you presently taking oral contraceptives?	☐	☐

PRECAUTIONS

DENTAL HISTORY

Last Visit: 0-6 months ☐ 6-12 months ☐ > 12 months ☐

When did you last have dental x-rays?

How often do you brush your teeth?

How often do you floss your teeth?

	Yes	No
1. Have you been seeing a dentist regularly?	☐	☐
2. Do any of your teeth ache?	☐	☐
3. Do your gums bleed when you brush?	☐	☐
4. Do you have any pain when you chew?	☐	☐
5. Do you feel that you have bad breath?	☐	☐
6. Have you ever experienced any blows to your jaw?	☐	☐
7. Have you ever had any implant surgery to your jaw?	☐	☐
8. Have you ever been advised to take antibiotics before dental appointments?	☐	☐
9. Are you being followed up by a dental specialist?	☐	☐
10. Are you nervous during dental treatment?	☐	☐

INFORMED CONSENT

I, the undersigned, hereby declare that I have read, understood and answered the above medical-dental questionnaire to the best of my knowledge. I also hereby promise to inform my dentist of any changes to my health.

I authorize the setting up of my dental file, its follow-up, as well as my registration on the recall list(s) of the treating dentist(s).

I have been informed that my file will be kept in the office at all times and that only the dentist(s) and his/her (their) auxiliary personnel will have access to it.

I also have been informed of my right to consult my file, to request that it be corrected, if necessary, and to remove my name from the recall list.

Signature Date

Patient or Responsible Party

I acknowledge that I have read the answers to the above questionnaire and that I have taken the customary measures, as the case may be.

Signature Date

Treating Dentist

SUBMIT RESET