Patient Information

AXIS Dental Group | Brampton
Tel: 905.452.7111 | Fax: 905.452.7410
WWW.**AXIS**DENTAL.CA

DATE ___________________________

Your cooperation in filling out the data on the confidential questionnaire is essential in aiding us to perform the highest standard of dental care. All information is strictly confidential and will remain with this office.

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. Name (last/first/middle) ___________________________

Age __________ Date Of Birth (DD/MM/YYYY) ______________ Sex ______________ Marital Status ______________

Address ___________________________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Email ___________________________

Employed By ___________________________ Occupation ______________

Student ☐ Yes ☐ No Student ID ___________________________

University/College ___________________________

Person Responsible For Account:

Name (last/first/middle) ___________________________

Date Of Birth (DD/MM/YYYY) ______________ Phone ______________

Address ___________________________

Employed By ___________________________ Occupation ______________

Dental Insurance ☐ Yes ☐ No Name of Company ___________________________

Policy No. ______________ % Covered __________ S.I.N. / Cert # ______________

Authorization Needed ☐ Yes ☐ No (If Yes Mailing Address Of Company Below)

Address ___________________________

May We Call You At Work? ☐ Yes ☐ No Work Phone ______________

Family Physician ___________________________ Phone ______________

Previous Dentist : ___________________________

Whom May We Thank For Referring You? ___________________________

In Case Of Emergency Notify (Name) ___________________________

Address ___________________________

Relationship ______________ Phone ______________

Confidential Medical History

Date of last physical examination ___________________________

01. Are you presently under the care of a physician? ☐ YES ☐ NO

Please Specify ___________________________

02. Are you presently taking any pills, drugs or medication? ☐ YES ☐ NO

Please Specify ___________________________

03. Have you taken any prolonged medication in the past? ☐ YES ☐ NO

Prescription or Non-Prescription? ___________________________

04. Have you had rheumatic fever? ☐ YES ☐ NO

05. Have had heart disease or murmur? ☐ YES ☐ NO

06. Do you become breathless easily? ☐ YES ☐ NO

07. Have you had abnormal bleeding? ☐ YES ☐ NO

08. Have you taken cortisone or steroids? ☐ YES ☐ NO

09. Do you have any allergies? ☐ YES ☐ NO

10. Do you have allergies to any drugs or medicines? ☐ YES ☐ NO

i.e. Penicillin. Please specify ___________________________

11. Have you ever been hospitalized and was surgery performed? ☐ YES ☐ NO

Please specify____

12. Have you ever had or been tested positive for any immunocompromising disease? ☐ YES ☐ NO

13. Have you gained or lost excessive weight recently? ☐ YES ☐ NO

14. Have you ever had radiation therapy for Cancer treatment? ☐ YES ☐ NO

15. Do you have or have you had? Please Tick

☐ High Blood Pressure	☐ Anemia	☐ Herpes	☐ Stroke	☐ Scarlet Fever	☐ Arthritis
☐ Low Blood Pressure	☐ Tuberculosis	☐ Nervous Problems	☐ Epilepsy	☐ Psychiatric Care	☐ Ulcer
☐ Thyroid Problems	☐ Diabetes	☐ Venereal Disease	☐ Fainting Spells	☐ Cancer	☐ Liver Trouble
☐ Are You Pregnant?	☐ Kidney Trouble	☐ Heart Trouble	☐ Hepatitis	☐ Asthma	☐ Chest Pain
☐ Blood Disorders	☐ Sinus Problems				

16. Are you currently in good health? ☐ YES ☐ NO

17. Is there anything else you think you should tell me?

Please speclfy____

18. Are you pregnant? (if applicable) ☐ YES ☐ NO

Dental History

Are you having any discomfort at this time? ☐ YES ☐ NO

Please specify______________________

Have you been under regular care by a dentist? ☐ YES ☐ NO

How long since your last dental visit?__________

What was done at that time?______________

Do your gums feel tender or swollen? ☐ YES ☐ NO

Have you ever been given general anaesthetic? ☐ YES ☐ NO

Please specify______________________

Have you ever been given local anaesthetic (freezing)? ☐ YES ☐ NO

Are you aware of any lump or swelling in your mouth? ☐ YES ☐ NO

Are you anxious to keep your natural teeth? ☐ YES ☐ NO

Are you interested in improving your smile by: ☐ Whitening ☐ Straightening ☐ Replace missing teeth ☐ Closing spaces

Describe in your own words what you would like done with your teeth ______________________________

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OFFICE POLICY: When an appointment is made, that time is specifically reserved for you only and will not be given to anyone else unless you call and cancel. It costs us approxlmately $400 per hour to keep our office open. When enough notice is not given (minimum 48 hours) to cancel, a $50 charge will apply (insurance plans do not cover this amount). Office policy is that; services are paid for at each visit as they are performed. However in certain circumstances arrangements for payment may be made by consulting doctor. Please indicate one of the following with check mark:

☐ I have dental insurance. ☐ I wish to pay each visit as the services are performed. ☐ I will like to know the total fee for all the work to be done, as well as the number of appointments necessary, so that I can pay equal portions at each appointment. ☐ I wish to discuss special arrangements for payment with the doctor.

CONSENT FOR TREATMENT: This is to certify that I, the undersigned, consent to the performing of the denial procedures agreed to be necessary or advisable including the use of general anaesthetic as indicated and I will asaume responsibility for fees associated with those procedures. I authorize this office to contact my previous dentist, medical doctor(s), Insurance oompany, plan administrative at work and share Information as needed. As well as, to submit insurance claims electronically.

Patient's Signature ______________________ Dentist's Signature ______________________

Date ______________________ Date ______________________