princessdental centre

Dr. Geoffery D. McIntosh Dental Corp., DMD

Dr. Guy Smith Dental Corp., DMD

Dr. Jill Gudmandson, DMD

PATIENT INFORMATION (Confidential)

Name _____ Birth date_____

Address _____ City _____ Prov _____ Postal Code_____

Home Phone _____ Work Phone _____ Cell Phone_____

Employer_____ Marital Status_____

E-mail_____ Gender_____

Emergency Contact/Parent Contact_____ phone #_____

How did you hear about us?_____

If you selected Family/Friend or other, whom Shall We Thank For Your Referral? _____

PRIMARY INSURANCE POLICY

Insurance Company _____ Policy #_____

Sub ID #_____

Policy Holders Name _____

Policy holders Date of Birth_____

Place of Employment_____ Work Phone _____

SECONDARY INSURANCE POLICY

Insurance Company _____ Policy #_____

Sub ID #_____

Policy Holders Name_____

Policy holders Date of Birth_____

Place of Employment_____ Work Phone _____

CREDIT CARD AUTHORIZATION

Our office will gladly direct bill your insurance company on your behalf. In order to direct bill your insurance company, we kindly ask that you leave an imprint of your credit card and any amounts not covered by your insurance company will be charged to your credit card and an email receipt sent. Please advise us of any future changes in your credit card.

I authorize Princess Dental Center to process invoice charges to my:

Credit Card Type:_____

Credit Card #:_____

Expiry Date:_____

Patient(s) on Account:_____

Cardholder Name:_____

E-mail Address: _____

Signature:_____

Date:_____

The balance remaining after we have received your insurance benefits, will be charged to your credit card. This authorization will be in effect until notice of cancellation is forwarded in writing to Princess Dental Center.

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PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

Patient Medical History

Physician _____ Physician's Office Phone_____

1. Are you currently under any medical treatment?_____ ☐ ☐
2. Have you been admitted to a hospital or needed emergency care during the past two years?_____ ☐ ☐
3. Are you currently taking any medications, including over the counter medications?_____ ☐ ☐
   Please list: _____
4. Have you ever had any complications following dental treatment?_____ ☐ ☐
5. Do you have or have had any of the following? Please check all that apply

☐ AIDS/HIV	☐ Fainting	☐ Radiation Therapy
☐ Anemia	☐ Glaucoma	☐ Respiratory Problems
☐ Arthritis	☐ Head Injuries	☐ Rheumatic Fever
☐ Artificial Joints	☐ Heart Disease	☐ Rheumatism
☐ Asthma	☐ Heart Murmur	☐ Sinus Problems
☐ Blood Disease	☐ Hepatitis	☐ Stomach Problems
☐ Cancer	☐ High Blood Pressure	☐ Stroke
☐ Diabetes	☐ Kidney Disease	☐ Tuberculosis
☐ Dizziness	☐ Liver Disease	☐ Tumors
☐ Epilepsy	☐ Mental Disorders	☐ Venereal Disease
☐ Excessive Bleeding	☐ Pacemaker	☐ Smoker

YES NO

6. Are you pregnant?_____ ☐ ☐
7. What is your due date?_____
8. Do you have any allergies to medications? *_____ ☐ ☐
9. Please list your allergies to any medications:_____

_____

_____

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY

	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____	☐	☐
2. Have you had an unfavorable dental experience?_____	☐	☐
3. Have you ever had trouble getting numb or had any reactions to local anesthetic?_____	☐	☐
4. Did you ever have braces, orthodontic treatment or had your bite adjusted?_____	☐	☐
5. Have you had any teeth removed or missing teeth that never developed?_____	☐	☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?__	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?_____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? If so please indicate who: _____	☐	☐
11. Have you ever experienced gum recession?_____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?_____	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?_____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?_____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?_____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth?_____	☐	☐

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?_____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? _____ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?_____ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?_____ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ___ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?_____ ☐ ☐
32. Do you wear or have you ever worn a bite appliance?_____ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change?_____ ☐ ☐
34. Have you ever whitened (bleached) your teeth?_____ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?_____ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work?_____ ☐ ☐

CONSENT FOR SERVICES

I agree to pay value of said services which shall be as billed, unless objected to by me, in writing, within the time for payment thereof. I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand my personal information disclosed is protected by the Privacy Act. I agree that Princess Dental can electronically file dental claims on my behalf.

I have read the above conditions of treatment and payment and agree to their content.

Signature_____ Date_____

Patient, parent, or guardian