File No.

# Langwinska Dentistry

Professional Corporation

315 Brant Ave.
Brantford, ON, N3T 3J8
(519) 756-3300

## Welcome to Our Office

**PLEASE PRINT. ALL INFORMATION IS CONFIDENTIAL**

☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Mas

Name: _____ (Last) _____ (First) _____ (Middle)

Date of Birth: _____ (Day/Month/Year) Marital Status: ☐Single ☐Married ☐Common-Law ☐Divorced ☐Widowed

Address: _____ (Number Street) _____ (City/Town) _____ (Postal Code) Tel: _____

Occupation: _____ Employed by: _____ Tel: _____

E-mail address: _____ @ _____

If a Child (Parent or Guardian's name): _____

Address (if different): _____ (Number/Street) _____ (City/Town) _____ (Postal Code) Tel: _____

**I prefer to visit this office on: Day M T W Th Fri Sat | Time 9-12 1-4 5-8**

### In Case of Emergency Notify:

Name: _____ Relationship: _____ Tel: _____

Is Another Member of Your Family or Relative a Patient at our Office: ☐Yes ☐No

Name: _____ (Last) _____ (First) _____ (Middle)

### Financial Information

Method of payment: ☐Dental Insurance (see below) ☐In-Office Financing (ask for details) ☐Cash ☐Cheque ☐Credit Card

Person responsible for this account: ☐Self ☐Spouse ☐Parent ☐Social Assistance ☐CINOT ☐ CAS ☐Other: _____

Dental Insurance: ☐ None ☐ One ☐ Dual

| Primary | Secondary |
|---|---|
| Name of Subscriber: _____ (Last First Middle) | Name of Subscriber: _____ (Last First Middle) |
| Date of Birth: _____ (Day/Month/Year) | Date of Birth: _____ (Day/Month/Year) |
| Employer/Group Policy Holder: | Employer/Group Policy Holder: |
| Insurance Company: | Insurance Company: |
| Group/Policy Number: Division: | Group/Policy Number: Division: |
| I.D. Number ,S.I.N or Certificate Number: | I.D. Number, S.I.N or Certificate Number: |
| **I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revoked. the same** | **I hereby assign my benefits, payable from claims submitted electronically, to Dr. Agnes Langwinska and authorize payment directly to her. This authorization shall continue in effect until the undersigned revokes the same.** |

**Who may we thank for your referral to our office**? _____

**Please initial this page here:** _____ (Patient's initials) **Reviewed by:** _____ (Doctor's Signature)

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## Confidential Medical History

Family Physician: _____ Tel. _____Specialist _____ Tel. _____

| | Yes | ? | No |
|---|---|---|---|
| Have you had a medical check-up within the past year? | ☐ | ☐ | ☐ |
| Are you presently under the care of a physician for any medical condition? If yes please specify: _____ | ☐ | ☐ | ☐ |
| Are you taking or have you recently taken any prescription or non-prescription drugs? If yes, please list them: _____ _____ | ☐ | ☐ | ☐ |
| Have you had or have any of the following: Rheumatic fever | ☐ | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | ☐ |
| Joint replacement e.g.: hip If yes, please specify date: _____ | ☐ | ☐ | ☐ |
| Have you been told to take antibiotic before dental treatment for medical reasons? | ☐ | ☐ | ☐ |
| Have you ever been hospitalized for any serious illnesses or operations? If yes, please specify: _____ | ☐ | ☐ | ☐ |
| Have you ever had any unusual or adverse reaction to any drugs? If yes, please list: _____ | ☐ | ☐ | ☐ |
| Do you have any allergic reactions: i.e. to food, metal, latex, pollen, hay? If yes, circle it or list others: _____ | ☐ | ☐ | ☐ |
| Do you bruise easily, bleed excessively from cut or injury? | ☐ | ☐ | ☐ |
| If yes, have you been diagnosed with any blood disorder? _____ | ☐ | ☐ | ☐ |
| Have you ever experienced the following: Chest pain | ☐ | ☐ | ☐ |
| Heart Attack | ☐ | ☐ | ☐ |
| Stroke If yes, date: _____ | ☐ | ☐ | ☐ |
| Do you have one of the following: High Blood Pressure | ☐ | ☐ | ☐ |
| Low Blood Pressure If yes, how they are controlled? _____ | ☐ | ☐ | ☐ |
| Do you smoke or chew tobacco? | ☐ | ☐ | ☐ |

**Do you have or have you ever had any of the following?** (please circle any that apply)

| | | | |
|---|---|---|---|
| Stomach intestinal problems | Cancer If yes, what type: _____ | Hepatitis, jaundice If yes, what type: A, B, C | Diabetes If yes how it is controlled? diet, pills, insulin and since when _____ |
| Arthritis | Asthma | Dry mouth | Osteoporosis |
| Thyroid problems | Drug/Alcohol dependency | Mental or nervous disorder | HIV AIDS Leukemia |
| Chronic bronchitis | Epilepsy | Kidney disease | |

**For women only**: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ ? ☐ N

If so, what is your due date? _____

**Is there any other health condition that we should know about?** _____

**NOTE: It is important to keep us updated about any changes in your health status.**

**Please initial this page here:** _____ Patient's initials **Reviewed by:** _____ Doctor's Signature

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## Confidential Dental History

| | Y | N |
|---|---|---|
| Are you having any pain or discomfort now? | ☐ | ☐ |
| Please tell us how we can help you:<br>A. Complete examination and discuss my treatment choices. | ☐ | ☐ |
| B. Emergency treatment now and set up appointment for a complete exam. | ☐ | ☐ |
| C. Just deal with my present problem. | ☐ | ☐ |
| Have you been under a regular care of a dentist? | ☐ | ☐ |
| If yes, was it less than 2 years ago? | ☐ | ☐ |
| Do you like to have yours and your family's dental records transferred to our office?<br>If yes, please provide your previous dentist's name: _____ | ☐ | ☐ |
| Have you been treated by a dental specialist?<br>☐ gums ☐ root canal ☐ ortho ☐ oral surgery ☐ other _____ | ☐ | ☐ |
| Are your teeth sensitive to: ☐ hot ☐ cold ☐ sweets ☐ biting ☐ other _____ | ☐ | ☐ |
| Do your gums bleed, feel tender or swollen when: ☐ brushing ☐ flossing ☐ occasionally | ☐ | ☐ |
| Are you aware of any ☐ loose teeth or ☐ shifting teeth? | ☐ | ☐ |
| Are you aware of any of the following: ☐ grinding or ☐ clenching your teeth<br>☐ breathing through your mouth<br>☐ biting on objects e.g. pencil, pipe | ☐ | ☐ |
| Do you experience or have you experienced any of the following: ☐ cracking<br>☐ popping ☐ locking ☐ difficulty in opening and closing ☐ pain in ears | ☐ | ☐ |
| Have you ever suffered an injury to your jaw? | ☐ | ☐ |
| Are you aware of any lumps or growth in your mouth? | ☐ | ☐ |
| Have you ever had difficulty with local anaesthetic (freezing)? | ☐ | ☐ |
| Are you satisfied with the appearance of your teeth?<br>If no, what would you like to change? ☐ color ☐ shape ☐ overall appearance | ☐ | ☐ |
| Do you have any preference for ☐ white or ☐ silver fillings. | ☐ | ☐ |
| On a scale of 1 – 10 (10 being perfect) how would you rate your smile?<br>1 2 3 4 5 6 7 8 9 10 (circle one) | | |
| Have you ever had concerns about your dental treatment?<br>_____ | ☐ | ☐ |
| Do you have any concerns regarding your dental visit? ☐ fear ☐ time ☐ money<br>☐ other _____ | ☐ | ☐ |

I, the undersigned, state that I have provided and accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history and I consent to my Physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as may be necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services provided to me or to my dependents.

M D Y

Patient (Parent, Guardian) Signature: _____ Date: _____

If parent or guardian, please print name: _____

**Please initial this page here:** _____ (Patient's initials) **Reviewed by:** _____ (Doctor's Signature)