

Welcome to Yonge Eglinton Periodontics. To help us provide you with the highest quality care, please complete both pages of this form.

Today's date \_\_\_\_\_

## personal information

Your Name  Dr.  Mrs.  Mr.  Ms. \_\_\_\_\_ Date of birth \_\_\_\_\_  
Preferred Name \_\_\_\_\_  
Home address \_\_\_\_\_ City \_\_\_\_\_ Postal \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_  
Email \_\_\_\_\_ Occupation \_\_\_\_\_  
Preferred contact number and method \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## insurance information

I do not have insurance.  
Insurance Company \_\_\_\_\_ SECONDARY Insurance Company \_\_\_\_\_  
Policy Holder's name \_\_\_\_\_ Policy Holder's name \_\_\_\_\_  
Date of birth of policy holder \_\_\_\_\_ Date of birth of policy holder \_\_\_\_\_  
Employer's name \_\_\_\_\_ Employer's name \_\_\_\_\_  
Policy number \_\_\_\_\_ Policy number \_\_\_\_\_  
Certificate number \_\_\_\_\_ Certificate number \_\_\_\_\_

## medical history

Please check if you have had any of the following:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV                      | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Kidney disease               | <input type="checkbox"/> Seizures/Epilepsy           |
| <input type="checkbox"/> Allergies                     | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Jaundice                     | <input type="checkbox"/> Skin rash                   |
| <input type="checkbox"/> Anemia/ Blood disease         | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Liver disease                | <input type="checkbox"/> Steroid therapy             |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Heart attack            | <input type="checkbox"/> Mitral valve prolapse        | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Artificial joints/replacement | <input type="checkbox"/> Heart conditions        | <input type="checkbox"/> Nervousness/mental disorders | <input type="checkbox"/> Stomach/intestinal problems |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Heart surgery           | <input type="checkbox"/> Osteoporosis medications     | <input type="checkbox"/> Thyroid disease             |
| <input type="checkbox"/> Cancer/Chemotherapy           | <input type="checkbox"/> Heart murmur            | <input type="checkbox"/> Pacemaker                    | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Chest pains/Angina            | <input type="checkbox"/> Hepatitis A             | <input type="checkbox"/> Respiratory problems         | <input type="checkbox"/> Ulcers                      |
| <input type="checkbox"/> Circulatory problems          | <input type="checkbox"/> Hepatitis B             | <input type="checkbox"/> Rheumatic/Scarlet fever      | <input type="checkbox"/> Venereal disease            |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Hepatitis C             |   |  |
| <input type="checkbox"/> Dizziness                     | <input type="checkbox"/> High/Low blood pressure |   |  |
| <input type="checkbox"/> Drug addiction                | <input type="checkbox"/> High cholesterol        |   |  |

When was your last physical? \_\_\_\_\_

Are you currently taking any medications, non-prescription drugs, vitamins, or herbal supplements? If so, please list.

Have you ever had an adverse reaction to any of the following drugs?

- |                                  |                                     |   |
|----------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex      | <input type="checkbox"/> Local anesthetic |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other _____      |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## medical history (con't)

Are you currently seeing a specialist? If yes, for what?

In the last year, have you been treated for any medical conditions?

Do you smoke? If so, how many per day? How many years?

Have you ever had a blood transfusion? If so, when?

### For women:

Are you pregnant? If so, what month are you in?

Are you nursing?

Are you taking birth control pills?

## dental history

Do you have or have you had any of the following?

- Looseness of teeth
- Bleeding during brushing or flossing
- Spontaneous bleeding from your gums
- Teeth grinding, clenching, nail biting
- Sensitivity to hot or cold
- Spacing between your teeth
- A bad taste or smell in your mouth
- Past orthodontic treatment
- Future orthodontic treatment
- A history of treatment for your gums
- Jaw pain
- Other \_\_\_\_\_

## your doctor and general dentist

Name of your general dentist \_\_\_\_\_

General dentist's tel # \_\_\_\_\_

Name of your physician \_\_\_\_\_

Physician's tel # \_\_\_\_\_

It is my responsibility to inform the dental office of Dr. Kay of any changes to my medical health. I authorize the dental staff to consult with my physician if there are any concerns regarding my medical health. I also authorize the dental staff to perform any necessary dental services during diagnosis and treatment with my informed consent.

I have reviewed the patient consent form for collection, use and disclosure of personal information. It explains how Andrew Kay Dentistry Professional Corporation will use my personal information and the steps being taken to protect my information. I know that the office has a privacy code and that I can ask to see the code at any time. I agree that the practice can collect, use and disclose personal information about (patient's name) \_\_\_\_\_ as set out in the office privacy policy. I authorize release to my insurance company or plan administrator of the information in claims submitted.

\_\_\_\_\_  
Signature of patient, parent or guardian

\_\_\_\_\_  
Printed name of patient, parent or guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

We are required to collect the following information in accordance with Ontario's Narcotics Safety and Awareness Act, 2010. The Ministry of Health and Long term Care (MOHLTC) requires this information to monitor prescription narcotics and other controlled substances. Please provide one of the following approved forms of identification and record the identification number in the space provided. Approved forms of patient identification include:

Ontario Health Card or other health cards issued by a Province or Territory in Canada: \_\_\_\_\_

**OR**

Valid Drivers License or Temporary Diver's License: \_\_\_\_\_