DR. ATUL DHIR DR. ALYSSA KOMADA DR. SEAN ST.MARIE DR. SOK SUN

LEGENDS DENTAL CENTRE

Therapeutic Alert

ALL INFORMATION IS KEPT CONFIDENTIAL

Full Name: _____

Date of Birth (DD/MM/YYYY):_____

Address: _____

_____ _____
City/Province Postal Code

Health Card Number: _____

Home Phone: _____ Cell phone: _____

Work Phone: _____ Driver's License#:_____

Email: _____

Place of Employment: _____

Who may we thank for referring you to us? _____

In case of an emergency, please notify:

Name: _____

Relationship: _____Telephone: _____

Please present insurance card to front desk

INSURANCE(S):

Provider: _____

Policy#: _____

Certificate/ID#: _____

Relationship to patient: _____

Name: _____DOB:_____

Please indicate if you have secondary

Secondary Details:

Provider: _____

Subscriber Name: _____

Policy#: _____

Certificate/ID#: _____

Relationship to patient: _____

Subscriber DOB: _____

****NIHB:**

Treaty Number:_____

DENTAL HISTORY

Previous Dentist/Dental Office: _____
How long since your last check up? _____Last cleaning:_____

Please circle **YES** or **NO** for the following:

Have you had:	Orthodontic Treatment ----------	YES	NO
	Periodontal (gum) Treatment ---	YES	NO
	Wisdom Tooth Extractions -----	YES	NO
	Root Canals ----------	YES	NO
	Dental Implants ----------	YES	NO
Do your gums bleed?----------		YES	NO
Are any of your teeth sensitive or loose?----------		YES	NO
Do you ever clench or grind your teeth? ----------		YES	NO
Do you have any problems with your jaw/chewing? ----------		YES	NO
Do you have any trouble with local anesthetic (freezing)? ---		YES	NO

How often do you floss? _____

How often do you brush? _____

Do you smoke?_____

MEDICAL HISTORY

Family Doctor's name: _____ Location:_____

ALLERGIES: _____

CURRENT MEDICATIONS:_____

Have you ever undergone bisphosphonate/bone/osteoporosis treatment? Yes / No
If yes, when and for how long?: _____

Are you currently seeing a physician for treatment or any medical conditions? Yes / No
If yes, please explain: _____

Have you had any major operations, illnesses or hospitalizations? Yes / No
If yes, please explain: _____

Please mark all that apply if you have or have had:

AIDS/HIV+	☐	Diabetes	☐	Mental Disorder/Depression	☐
Anemia	☐	Epilepsy	☐	Sinus Trouble	☐
Arthritis/Osteoporosis	☐	Hay Fever	☐	Ulcer	☐
Asthma/COPD	☐	Hepatitis	☐	Heart Attack/Stroke	☐
Blood Disorder/Transfusion	☐	High Blood Pressure	☐	Thyroid Problems	☐
Heart Disease/Surgery	☐	Liver/Kidney Disease	☐	Tuberculosis	☐
Cancer	☐	Dizziness/Fainting	☐	STD/HPV	☐
Congenital Heart Defects	☐	Rheumatic Fever	☐	Multiple Sclerosis	☐
Artificial Joint Replacement	☐	Anxiety/Nervous	☐	Respiratory Problems	☐

Patient/Guardian Consents:

Although we will assist in direct billing, ultimately it is your responsibility to know your insurance plan maximums and other coverage details. **You are responsible for any balance owing on your account upon completion of procedures.**

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable including the use of local anesthetic as indicated. I agree to authorize my dental office to contact me using the information provided, in order to inform me of updates, appointment reminders, and important dental related information whether via phone, text and/or email. I give consent and authorization of your office to request the release of records from previous offices.

24 hours is required to cancel or reschedule an appointment
****Less than 24 hours or a No Show may result in a $50 fee****

Patient or Guardian Signature: _____Date: _____

Dentist Signature: _____ Date: _____