LEGENDS DENTAL CENTRE

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

ALL INFORMATION IS KEPT CONFIDENTAL

Therapeutic Alert

Full Name: _____

Date of Birth (DD/MM/YYYY) _____

Address: _____

(City/Prov)_____(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 a secondary

Secondary Details:

Provider: _____

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? _____

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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: _____

Mental Disorder/Depression	
Sinus Trouble	
Ulcer	
Heart Attack/Stroke	
Thyroid Problems	
Tuberculosis	
STD/HPV	
Multiple Sclerosis	
Respiratory Problems	

Diabetes	
Epilepsy	
Hay Fever	
Hepatitis	
High Blood Pressure	
Liver/Kidney Disease	
Dizziness/Fainting	
Rheumatic Fever	
Anxiety/Nervous	

AIDS/HIV	
Anemia	
Arthritis/Osteoporosis	
Asthma/COPD	
Blood Disorder/Transfusion	

LEGENDS DENTAL
CENTRE

Heart Disease/Surgery	
Cancer	
Congenital Heart Defects	
Artificial Joint Replacement	

Please mark all that apply if you have ever had:

Patient/Guardian Consent:

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 my previous office.

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: _____