STONEBRIDGE DENTISTRY
1 Market Lane, Unit 9
Wasaga Beach, On L9Z 0B6
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Tel: 705-422-2490 Fax: 705-422-2493

NEW PATIENT FORM

Patient Information (please print)

Title: Mr/Mrs/Ms/Miss/Mast Name: _____
First Initial Last

Address: _____
Street Apt City Prov Postal code

Cell#_____Home#_____

Date of birth ___/___/_____ Email_____
D M Y

Name of spouse/ Parents/ Gaurdian_____

Emergency contact_____Phone#_____

Who can we thank for referring you?_____

Financial Information

Do you have dental insurance? Yes/No/More than one

Primary Insurance	**Secondary Insurance**
Subscriber Name_____	Subscriber Name_____
Policy #_____ Id #_____	Policy #_____ Id #_____
Subscriber Date of Birth (D/M/Y) ___/___/	Subscriber Date of Birth (D/M/Y) ___/___/
Employer_____Ins Co_____	Employer_____Ins Co_____
Relationship to Subscriber _____	Relationship to Subscriber _____

Our office is happy to file claims electronically on your behalf, so that in many cases, we will receive your insurance reimbursement.
As such, payment of your dental visit is expected at the time of service should there be any balances.
Please let your front desk staff know ahead of time, in the event that you are unable to make payment when it is due, so that other options can be discussed with you at that time.

Medical History: (Confidential as per PIPEDA legislation)

Name of family Physician _____Phone _____Date of last physical _____

Are you being treated for any medical condition? If Yes, which_____
Are you taking any drugs or medications at this time:
Drug: _____Reason: _____
Are you taking any Herbal or Vitamin Supplements?
Supplement _____Reason _____
Do you have any drug allergies or adverse effects? (Penicillin, Sulfonamide, Aspirin, Codeine, Local Anesthetic)
_____
Any Latex, Nickel, or General Anesthia Allergies? _____
Do you bruise easily or bleed for a prolonged period of time? _____
Do you smoke? If so, how much per day, and how long?_____
Have you ever fainted, had shortness of breath or chest pains?_____
Women: Are you pregnant? YES/NO, Nursing? YES/NO, Using Birth control? YES/ NO
Have you in the past, or are currently taking cortisone-based medications such as Prednisone?_____

Do you have or have you ever had any of the following medical conditions?

☐ Artificial Joints ☐ Anemia ☐ Bone Density ☐ Meds ☐ Blood Thinner ☐ Meds ☐ Cancer ☐ Radiation ☐ Chemotherapy ☐ Diabetic ☐ Infective ☐ Endocarditis ☐ Hep A/B/C ☐ H.I.V Positive ☐ Hemophilia ☐ Blood Pressure H / L ☐ Pacemaker ☐ Stroke ☐ Heart Issues	☐ Asthma ☐ Circulation ☐ Problems ☐ Cortisone/Steroids ☐ Drug/Alcohol ☐ Dependency ☐ Eating Disorder ☐ Epilepsy ☐ Glaucoma ☐ Head/Neck injury ☐ Herpes ☐ Hodgkin Disease ☐ Hyperglycemia ☐ Jaundice ☐ Kidney Disease ☐ Liver Disease ☐ Lung Disease	☐ Malignant ☐ Hypothermia ☐ Mental Nervous ☐ Disorder ☐ Mitral Valve ☐ Prolapse ☐ Organ Transplants ☐ Psychiatric Disorder ☐ Rheumatic Fever ☐ Sickle Cell ☐ Sinus Problem ☐ Thyroid Problem ☐ Tuberculosis ☐ Ulcers Other _____	**List Recent Surgeries or hospital visits:**

Dental History:

Last Dental Checkup and Cleaning? _____How Frequently do you visit? _____
Do you usually take antibiotics before a procedure?_____
Are you looking for Comprehensive Dental Care, or Emergency Care Only? _____
Do you have a history of Gum Disease? _____Treated?____Untreated?_____
Have you seen a Periodontist? _____If Yes, when?_____
Are your teeth sensitive to Sweets? _____Hot? _____Cold?
Have you been diagnosed with TAU (Jaw Joint) problems? ___If Yes, when?____Treated/Untreated?
Does your Jaw Joints "Click" or "Pop' when you open? _____
Are you aware If you grind or clench your teeth at night? _____
Have you had orthodontic work done (braces)? _____
Do you wear any oral appliances?_____Removable or Fixed? _____
Have you Professionally Whitened your teeth before? Yes_____No ___
Are you happy with your smile? _____

GENERAL RELEASE: I, the undersigned, certify that the information contained in the medical and dental history Is correct to the best of my knowledge. I consent to the release of medical information from my medical doctor, or other health care providers, if required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that payment for my dental treatment Is due at the time of service, unless otherwise arranged for in advance with office management. I understand that I am responsible for my account with this dental office, and that all of my dependents, and I will not allow payments to be in arrears.

We need to have your consent to begin communicating with you by text or email.
Email and text messaging allows us to communicate efficiently for the benefit of our patients. At the same time, we recognize addressed to the wrong person or accessed improperly while in storage or during transmission.
HIPAA requires that providers take reasonable steps to protect against these risks but acknowledges that a balance must be struck between the need to secure personal information and the need to ensure that clinicians can efficiently exchange important patient care information. Stonebridge Dentistry has implemented such measures through obtaining informed consent from patients using any potentially unencrypted electronic format.
By signing this form, you give consent to our office to communicate with you via

Text your mobile number ☐	Mobile number:
Email your email address ☐	Email Address:
Both text & Email address ☐	
I do not wish to receive either text or email ☐	

_____ _____ _____
Signature Print Name Date