WELCOME TO OUR OFFICE

Dr. Samson Lee
Credit River Dental Centre
114 Lakeshore Rd. E.
Port Credit, ON L5G 1E4
T: (905) 278 - 4297

The following information is required by the Dentist to assist in proper diagnosis and treatment. Please feel free to ask the receptionist for help in completing this form. *PLEASE PRINT.*

ALL INFORMATION IS STRICTLY CONFIDENTIAL

Date (M/D/Y) ______________

ADULT PATIENT or PARENT/GUARDIAN (if child see below)

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.

Are you the: ❑ PATIENT ❑ PARENT ❑ GUARDIAN

Name: ______________________________________
(last) (first) (initial)

Address: ______________________________________
(apt./suite #) (street) (city) (province) (postal code)

Date of Birth: ______________ Age: ______ Sex: ______ Marital Status: ______________
(month/day/year)

Home Phone: ( ) ______________ Employer: ______________

Cel Phone: ( ) ______________ Occupation: ______________

E-Mail: ______________ Work Phone: ( ) ______________ (ext) ______

CHILD or ADULT UNDER GUARDIANSHIP (if Patient)

Name: ______________________________________ ______________
(last) (first) (initial) **(prefers to be called)**

Address: ______________________________________
(if different) (apt./suite #) (street) (city) (province) (postal code)

Date of Birth: ______________ Age: ______ Sex: ______ Grade: ______________
(month/day/year)

Home Phone: ( ) ______________ School: ______________
(if different)

HOW DID YOU HEAR ABOUT US?

❑ Walk By ❑ Yellow Pages ❑ Index/Pink Pages ❑ Ad/Promotion ❑ Internet ❑ Referral (name) ______________

Family Physician: ______________ Phone: ( ) ______________

Address: ______________________________________
(suite #) (street) (city) (province) (postal code)

Medical Specialist: ______________ Phone: ( ) ______________

Emergency Contact: ______________________________________ ______________
(last) (first) (initial) **(relationship)**

Occupation: ______________ Employer: ______________ Phone: ( ) ______________ (ext) ______

Closest relative: ______________ Phone: ( ) ______________

Is another family member a patient at our office? ______________

PERSON RESPONSIBLE FOR ACCOUNT:

❑ Self ❑ Guardian ❑ Spouse

Method of payment: ❑ Cash ❑ Credit Card ❑ Debit

PRIMARY DENTAL INSURANCE:		SECONDARY DENTAL INSURANCE:	
NAME OF INSURED	DATE OF BIRTH (M/D/Y)	NAME OF INSURED	DATE OF BIRTH (M/D/Y)
EMPLOYER		EMPLOYER	
INSURANCE CARRIER OF INSURED		INSURANCE CARRIER OF INSURED	
GROUP/POLICY NUMBER	DIVISION	GROUP/POLICY NUMBER	DIVISION
CERTIFICATE/I.D. NUMBER		CERTIFICATE/I.D. NUMBER	

Credit River Dental Centre 114 Lakeshore Rd. E., Unit 3, Port Credit ON. L5G 1E4 - T:(905) 278-4297

DENTAL HISTORY

1. Reason for seeing us: ______________________________

2. When was your last dental visit? __________ Last hygiene appt.? __________ Last set of x-rays? __________

3. What do you use to clean your teeth? ❑ Toothbrush ❑ Dental floss ❑ Sulcabrush ❑ Mouthwash ❑ Proxabrush
   Others? Please list: ______________________________

4. Do your gums bleed spontaneously or when brushing or flossing? ❑ Yes ❑ No ❑ Not Sure

5. Are any of your teeth sensitive to: ❑ Hot ❑ Cold ❑ Sweet ❑ Biting

6. Does your jaw pop or click when you open widely? __________ If so, is there any pain on doing so? __________

7. Difficulty in opening or closing? ❑ Yes ❑ No ❑ Not Sure

8. Do you have any of the following oral habits?
   i) Grind or clench your jaw day or night? ❑ Yes ❑ No ❑ Not Sure If so, frequency? __________
   ii) Mouth breathing while awake or asleep? ❑ Yes ❑ No ❑ Not Sure
   iii) Placing foreign objects in your mouth (pencils, nails, pins, fingernails)? ❑ Yes ❑ No

9. Do you have any concerns about your dental visit? ❑ Fear ❑ Pain ❑ Time ❑ Money ❑ Embarrassment

10. Please check any of the following that you have had, and circle any that you may be interested in:

❑ Orthodontics	❑ Repairing chipped teeth	❑ Improving gum health	❑ Improving your smile
❑ Bonding	❑ Whitening teeth	❑ Improving your bite	❑ Sports mouth guard
❑ Crowns	❑ Replace missing teeth	❑ Improving breath odor	❑ Nightguard/spint
❑ Snoring appliance			

11. i) On a scale of 1 to 10, how would you rate your overall smile/oral health? __________
    ii) On a scale of 1 to 10, what would you like your overall smile/oral health to be? __________
    iii) What would you like to change to get from where you are to where you want to be? __________

INFORMED CONSENT/GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions regarding my medical/dental history. Should there be any change to my health status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for all fees associated with these services.

Signature: ______________________________ ______________________________
❑ PATIENT ❑ PARENT ❑ GUARDIAN (Print name of Guardian)

Reviewed by treating Dentist: ______________________________ **Date:** __________
(month/day/year)