New Patient Medical History

Harbour Grace Dental Hygiene

Harbour Grace Office & Privacy Policy

To ensure your dental appointment at Harbour Grace Dental Hygiene is pleasant, please take a moment to familiarize yourself with our office policies and procedures.

Due to the Canadian Personal Privacy Act, we are unable to access any specific information from your dental insurance company regarding your dental plan. It is your responsibility to know the parameters of your coverage, such as annual maximums, frequencies, renewal dates, and any other limitations.

Please understand that it is your responsibility to keep track of your upcoming dental appointment. As a courtesy, we send out reminder emails to you 2-3 weeks before a requested appointment and make confirmation calls or send text reminders before all appointments. Although we will make every effort to contact you before any appointment, it is ultimately your responsibility to ensure that you will be at your appointment unless other arrangements have been made in advance with our office.

Bearing these special needs in mind, our clinic requires a minimum
of 24 hours notice if an appointment needs to be rescheduled.

In accordance with the Privacy Regulations. we are required to maintain the confidentiality of your health information. This describes how we use and disclose your protected health information to carry out treatment, payment of health care operation and for other purposes that we are permitted or required by law. We will use and disclose your protected health information to provide, coordinate, or manage your dental care and any related services. For example: your health/dental information may be provided to a dentist whom you have been referred, or a dentist, physician or health care provider who becomes involved in your care. We may also use and disclose dental information about you in order to obtain payment for services rendered. Such disclosures may be made to you, an insurance company, responsible party or third party. We may also tell your health plan about treatment you are going to receive to obtain prior approval or to determine whether your plan will cover treatment.

Consent *

- ○ I understand & consent
- ○ I do not understand & do not consent

Personal Information

Please provide the information below.

First name

Preferred name

Title

Last name

Middle name

Gender

Birthdate

Email

Cell phone

Home phone

Work phone

☐ I want to receive text message and email reminders for my appointments

Address 1

Address 2

City

Province

Postal code

Country

Emergency contact name

Emergency phone

How did you hear about us?

Additional details

MCP Info

MCP Number:

Primary Insurance

Insurance carrier name

Policy #

Subscriber #

Subscriber first name

Subscriber last name

Relationship to subscriber

- [ ] Self
- [ ] Spouse
- [ ] Child
- [ ] Common Law Spouse
- [ ] Other

Subscriber birthdate

Additional details

Secondary Insurance

Insurance carrier name

Policy #

Subscriber #

Subscriber first name

Subscriber last name

Relationship to subscriber

- [ ] Self
- [ ] Spouse
- [ ] Child
- [ ] Common Law Spouse
- [ ] Other

Subscriber birthdate

Additional details

Medical Conditions

Please select all the medical conditions you have from the list below. If you have a medical condition or a concern not listed, please specify it in the additional details.

- [ ] AIDS/HIV Positive
- [ ] Alzheimer's Disease
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Arthritis/Gout
- [ ] Artificial Heart Valve
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Blood Disease
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chest Pains
- [ ] Chronic Cough
- [ ] Chronic myelogenous leukemia
- [ ] Circulation Problems
- [ ] Diabetes
- [ ] ehlors-danors syndrome
- [ ] Emphysema
- [ ] Epilepsy/Seizures
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head or Neck Injuries
- [ ] Heart Attack/Failure
- [ ] Heart Murmur
- [ ] Heart Pace Maker
- [ ] Heart Surgery
- [ ] Hemophilia
- [ ] Hepatitis A
- [ ] Hepatitis B or C
- [ ] High Blood Pressure
- [ ] Kidney Problems
- [ ] Liver Disease
- [ ] Lung Disease
- [ ] Mental/Nervous Disorder
- [ ] Organ/Medical Transplant
- [ ] Sickle Cell Disease
- [ ] Sinus Trouble
- [ ] Stroke
- [ ] Thyroid Condition
- [ ] Transverse Myelitis
- [ ] Trygeminal Neuralgia
- [ ] Tuberculosis

Additional details

Medications

Please add all the medications you currently take for your medical conditions.

Medications

Additional Information

Do you smoke or use any other tobacco products? *

Yes

No

Do you use marijuana? (medicinal or recreational) *

Yes

No

Have you ever had radiation therapy? *

Yes

No

Are you currently pregnant? *

Yes

No

What is the date of your last dental cleaning (approx)?

Name of Previous Dental Office/Dentist

Chek all that apply

- Bleeding gums when brushing
- Bleeding gums after flossing
- TMJ
- Clicking Jaw
- sensitivity to cold
- sensitivity to hot
- sensitivity to sweet
- Food catches in tooth

Allergies

Please select all the allergies you have from the list below. If you have an allergy or a concern not listed, please specify it in the additional details.

- Acetaminophen
- Amoxicillin
- Aspirin
- Codeine
- Contact Dermatitis
- Environmental
- Erythromycin
- Fragrances
- Ibuprofen
- Latex
- Local Anesthetic
- Metal
- Morphine
- Nuts
- PenV
- Sulpha
- Tetracycline

Additional details

Signature

Your Name OR Name of Parent/Guardian (if signing for individual who is under the age of 19)

Date

Relationship to Patient

Print name

Today's date