HORIZON
FAMILY DENTISTRY
LINDSAY
Toothfully Yours....Always!

40 Cambridge St. South, Lindsay ON K9V 3B8
(705) 320-8833 • www.horizonfamilydentistry.ca

PATIENT INFORMATION

Welcome to Our Dental Office!

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private, and is protected by doctor-patient confidentiality. Please fill in the entire form.

PERSONAL INFORMATION

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Mstr.

First Name: _____ Prefered Name: _____
Last Name: _____ Date of Birth (DD/MM/YY): _____/_____/_____
Home Address: _____ Apt: _____
City: _____ Postal Code: _____
Email: _____ Home Tel: _____
Work Tel: _____ Cell: _____
Employer: _____ Occupation: _____
Physician: _____ Physician's Phone No: _____
Previous Dentist: _____
Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Primary Policy Holder: _____ Secondary Policy Holder: _____
Relation: ☐ Self ☐ Spouse Other: _____ Relation: ☐ Self ☐ Spouse Other: _____
Date of Birth of Insured (DD/MM/YY): _____/_____/_____ Date of Birth of Insured (DD/MM/YY): _____/_____/_____
Insurance Co: _____ Insurance Co: _____
Policy Plan#: _____ Division/Sect#: _____ Policy Plan#: _____ Division/Sect#: _____
Certificate ID#: _____ Certificate ID#: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Tel: _____

MEDICAL HISTORY

	YES	NO
Are you being treated for any medical condition at the present or have you been treated within the last year?	☐	☐
If yes, specify: _____		
When was your last medical check-up? _____		
Has there been any change in your general health in the past year?	☐	☐
Are you taking any medications, non-prescription drugs, or herbal supplements of any kind?	☐	☐
If yes, please list them: _____		
_____		
_____		
Do you have any allergies? ☐ Latex ☐ Metal/Jewelry ☐ Other e.g. Hayfever, Foods _____	☐	☐
Have you had an unusual reaction to any drugs or medicines?	☐	☐
☐ Penicillin ☐ Sulfonamide ☐ Aspirin ☐ Codeine ☐ Local Anesthetic ☐ Other: _____		
Have you ever taken cortisone or steroid medication?	☐	☐

	YES	NO
Do you have or have you ever had any heart problems?	☐	☐
Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?	☐	☐
Do you have or have you ever had jaundice, hepatitis or liver disease?	☐	☐
Do you have a bleeding problem or bruise easily?	☐	☐
Do you have any conditions that could affect your immune system eg. AIDS, HIV infection, Leukemia etc?	☐	☐
Do you smoke or chew tobacco products? If yes, how much? _____	☐	☐
Have you ever been hospitalized for any serious illnesses or operations?	☐	☐
Do you have any prosthetic or artificial joints?	☐	☐

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

☐ Chest Pain/Angina	☐ Heart Attack	☐ High Blood Pressure	☐ Emphysema	☐ Asthma
☐ Epilepsy/Seizures	☐ Thyroid Disease	☐ Kidney Disease	☐ Cancer	☐ Chemotherapy/Radiation
☐ Psychiatric Disorder	☐ Tuberculosis	☐ Arthritis	☐ Stroke	☐ Osteoporosis/Osteopenia
☐ Stomach Ulcers	☐ Diabetes	☐ Drug/Alcohol Dependency	☐ Pacemaker	☐ Sinusitis
☐ Sleep Apnea	☐ Problems with Anesthesia			

	YES	NO
Are there any conditions or diseases not listed above that you have or have had?	☐	☐

If yes, please list:_____

For women only: Are you pregnant, breastfeeding, or taking birth control pills?	☐	☐

DENTAL HISTORY

What are the main reasons for your visit? _____

When was your last dental visit? _____

When did you last have dental x-rays? _____

How often do you: Brush your teeth? _____ Floss your teeth? _____

	YES	NO
Are any of your teeth sensitive to cold, heat or chewing?	☐	☐
Do you get food jammed in between your teeth?	☐	☐
Do your gums bleed when brushing or flossing?	☐	☐
Have you ever had professional treatment for your gums?	☐	☐
Are you aware of clenching/grinding your teeth during the day or night?	☐	☐
Do your jaw joints click, pop, or make grating noises?	☐	☐
Have you ever been in a vehicle accident or experienced any blows to your jaw?	☐	☐
Have you ever had any implant surgery in one or both of your jaws or jaw joints?	☐	☐

If "yes", who performed the surgery and when was it done?_____

Are you being followed up by a dental specialist?	☐	☐
Do you suffer from headaches? If "yes", approximately how many per month?_____	☐	☐
Have you ever had your wisdom teeth removed?	☐	☐
Have you had orthodontic treatment (braces)?	☐	☐
If you play sports, do you wear a mouthguard?	☐	☐

I certify that I have read, understood and accurately completed the personal, medical and dental histories, to the best of my knowledge, and not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general and local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.
Please email **lindsay@horizonfamilydentistry.com** when completed

Signature of Patient (Parent/Guardian)	DD/MM/YYYY	Reviewed by Dentist	DD/MM/YYYY