ANCHOR DENTAL CENTRE

New Patient Information

Last Name _____ Date of Birth _____

First Name _____ Preferred Name _____ Gender _____

Mailing Address _____ Marital Status _____

City _____ Province _____ Postal Code _____

Email Address _____ Home Phone _____ Cell Phone _____

Emergency Contact _____ Phone _____ Relationship _____

How did you find our office? _____ Family/Friend Referral _____

_____ Internet Search _____ Walk By _____ Other: _____

Medical Information

Please circle Yes or No as applicable

Name of Physician _____ Last Examination _____ Phone _____

Are you in good health? YES / NO Are you on a diet at this time? YES / NO

Have you been admitted to a hospital or needed emergency care during the past two years? YES / NO

Do you have, or has a Physician ever informed you that you have or have had, any of the following:

HIV / AIDS……	YES	NO	Allergies……	YES	NO	Anemia……	YES	NO
Asthma……..	YES	NO	Artificial Joints……..	YES	NO	Blood Disease……	YES	NO
Blood Transfusion……..	YES	NO	Cancer……	YES	NO	Chemotherapy……	YES	NO
Contact Lenses……...	YES	NO	Diabetes……	YES	NO	Dizziness……...	YES	NO
Epilepsy…….	YES	NO	Excessive Bleeding……..	YES	NO	Fainting…….	YES	NO
Glaucoma……	YES	NO	Growths…….	YES	NO	Hay Fever……..	YES	NO
Head Injuries……..	YES	NO	Heart Disease……	YES	NO	Heart Murmur……	YES	NO
Hepatitis…….	YES	NO	High Blood Pressure……	YES	NO	Jaundice…….	YES	NO
Kidney Disease……..	YES	NO	Liver Disease……	YES	NO	Mental Disorders……..	YES	NO
Nervous Disorders…….	YES	NO	Pacemaker…….	YES	NO	Prosthetic Heart Valve..	YES	NO
Psychiatric Care……	YES	NO	Radiation Treatment…….	YES	NO	Respiratory Problems…	YES	NO
Rheumatism……..	YES	NO	Sinus Problems……	YES	NO	Smoker……..	YES	NO
Stomach Problems……	YES	NO	Stroke……	YES	NO	Tuberculosis……..	YES	NO
Tumors……..	YES	NO	Ulcers……	YES	NO	Venereal Disease……..	YES	NO

Are there any conditions not listed above that you presently have or had? YES / NO

If yes, please explain _____

_____

Have you ever had an adverse reaction to any medicines or injections such as:

Antibiotics……..……..	YES	NO	Aspirin……...	YES	NO
Local Anesthesia (Freezing)	YES	NO	Penicillin……	YES	NO
Codeine…….	YES	NO	Sulpha……	YES	NO

Please list any Current Medications (and dosages)

_____ _____ _____

_____ _____ _____

_____ _____ _____

For Female Patients Only

Are you pregnant or nursing? YES / NO If pregnant, how many months are you? _____

Are you taking birth control pills? YES / NO Type? _____

Dental Information

Last General Dentist _____ Phone Number _____

Date of last visit _____ Date of last cleaning _____

When were your last x-rays done? _____

Have you requested your records to be transferred to us? YES / NO

Do you floss your teeth? YES / NO

If yes, how often? _____

What kind of toothbrush do you use? Manual / Electric / Both

If electric, what make or model is it? _____

Have you ever had complications following dental treatment? YES / NO

If yes, reason: _____

If yes, what did you take? _____

Have you been advised to take antibiotics prior to dental treatment? YES / NO

If yes, reason: _____

Have you ever had a complication or a reaction to dental anesthetics? YES / NO

If yes, please describe _____

Do you snore? YES / NO Do you clench or grind? YES / NO Do you regularly experience bad breath? YES / NO

SMILE DESIGN

Are you satisfied with the appearance of your teeth? YES / NO

Would you like a whiter smile? YES / NO

Have you had orthodontic (braces) treatment? YES / NO

Would you like straighter teeth? YES / NO

Is there anything specific about your teeth that you would like changed? YES / NO

If yes, please explain _____

ANCHOR
DENTAL CENTRE

Insurance Information

We are happy to submit directly to your insurance company for you and require the following information to do so.

Primary Coverage

Insured's First Name _____ Last _____ Date of Birth _____

Is the insured a patient? YES / NO Employer: _____

Insurance Company _____ Group/Policy # _____ Cert/ID # _____

Recall Frequency _____ SC/RP Units _____ Deductible _____ / _____ (family)

Basic Coverage _____ % Maximum $ _____ Major Coverage _____ % Maximum $ _____ Max if combined $ _____

Patient's relationship to insured Self / Spouse / Child / Other : _____

Secondary Coverage

Insured's First Name _____ Last _____ Date of Birth _____

Is the insured a patient? YES / NO Employer: _____

Insurance Company _____ Group/Policy # _____ Cert/ID # _____

Recall Frequency _____ SC/RP Units _____ Deductible _____ / _____ (family)

Basic Coverage _____ % Maximum $ _____ Major Coverage _____ % Maximum $ _____ Max if combined $ _____

Patient's relationship to insured Self / Spouse / Child / Other : _____

Who is financially responsible for your account? _____

Patient Confirmation

To the best of my knowledge, I have answered every question on these forms completely and accurately. I will inform my dentist of any change in my health / medications and staff regarding any changes to my insurance.

Date	Patient Name	Signature of Patient / Guardian