



**PERSONAL INFORMATION**

Referred By:  Person  Radio  Website  Other

Male  Female

Last Name		First Name	Preferred Name
Mailing Address		City/Province	Postal Code
Date of Birth			
Home Phone	Work Phone	Cell Phone	Other Phone
Email			
Spouse/Parent(s) Name(s)		Patient/Parent(s)' Employer	Spouse's Employer

**MEDICAL INFORMATION**

Medical Doctor/Physician's Name: \_\_\_\_\_

Are you under a physician's care? Yes or No

If yes, why? \_\_\_\_\_

Has your physician advised you to take antibiotics before dental procedures? Yes or No

Have you ever had a serious illness or surgery? Yes or No

If yes, explain \_\_\_\_\_

Please list all medications you are presently taking by name:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had an allergic reaction to any of the following? Please circle.

Penicillin Yes or No      Advil/Tylenol Yes or No      Codeine Yes or No

Latex Yes or No      Metals Yes or No

Other Medicine. What? \_\_\_\_\_

Have you been treated or do you have any of the following:

Asthma Yes or No      Heart Murmurs Yes or No

Haemophilia Yes or No      Von Willebrand Disease Yes or No

Stroke Yes or No      Kidney Disease Yes or No

Pacemaker Yes or No      Liver Disease Yes or No

Hepatitis Yes or No      Rheumatic Fever Yes or No

Epilepsy Yes or No      Artificial Valve Implant Yes or No

Tuberculosis Yes or No      Diabetes *Type I or Type II (circle type)* Yes or No

Have you ever been treated for or told you have heart disease? Yes or No

Do you take any form of blood thinner? Yes or No

If yes, what? \_\_\_\_\_

Do you have high or low blood pressure? High or Low or Normal

If you have high or low blood pressure, is it controlled? Yes or No

Have you ever had radiation therapy, chemo treatment, or cancer? Yes or No

Have you bled excessively after being cut or injured? Yes or No

Have you ever taken Fosamax, Zometa, Aredia (Bisphosphonates) for osteoporosis? Yes or No  
Do you have any disease, condition, or problem not listed? Yes or No  
If yes, what? \_\_\_\_\_  
Do you smoke or use any other form of tobacco? Yes or No  
If yes, how often? \_\_\_\_\_  
If you are female, are you pregnant? Yes or No  
If yes, due date? \_\_\_\_\_

### DENTAL HISTORY

Previous dentist's name \_\_\_\_\_ How long has it been since your last dental visit? \_\_\_\_\_

Are you aware of any dental problems? \_\_\_\_\_ Are you happy with the appearance of your teeth? \_\_\_\_\_

Have you ever had any problems or complications with previous dental treatment? If yes, explain.  
\_\_\_\_\_

If an appointment must be rescheduled we require 24 hours notice. Messages can be left at all times, including evenings and weekends at 326-6647. We reserve the right to charge for missed appointments and/or failure to provide sufficient notice prior to a cancelled appointment. These fees must be paid prior to being seen at your next visit. You are responsible for these fees; your insurance company will not be billed. We reserve the right to cancel an appointment if we are unable to contact the patient, parent or guardian 24 hours before the appointment time.

### INSURANCE

Subscriber: \_\_\_\_\_

I hereby assign my benefits payable from claims submitted electronically to Dr Luke A. Singh Dental Corporation and authorize payment directly to him. I authorize release to the dental benefits company the information contained in claims submitted electronically

I understand that the charges may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to Dr. Luke A. Singh for the cost of treatment provided.

\_\_\_\_\_  
Signature of Subscriber

### RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care, including the use of local anaesthetic as indicated.

I authorize the release of any information concerning my/my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information, including x-rays, concerning my/my child's health care, advice and treatment to another dentist, and/or health care professional I understand that I am financially responsible for payment in full to Dr. Luke A. Singh for services rendered.

I attest to the accuracy of the information in this chart.

Patient's/Parent's/Guardian's Name (Please Print) \_\_\_\_\_

Patient's/Parent's/Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_