Medical Alert _____

Welcome to Dr. Beena George Dentistry

Patient ID#_____

Please fill out the following information. PLEASE PRINT.

Patient Information

The patient is an: ☐Adult ☐Child ☐Adult under Guardianship Name of Guardian: _____

Name: _____
First Middle Last

Marital Status: _____ Sex: ☐Male ☐Female ☐Other Date of Birth: ___/___/____
DD MM YYYY

Address: _____
Street Apt. City Prov. Postal Code

Home Tel: (_____) _____ Work Tel: (_____) _____ Ext.___ Cell Tel: (_____) _____

Email address: _____ Fax: _____

Emergency Contact: _____ Tel: (_____) _____

Family Doctor: _____ Tel: (_____) _____

Whom may we thank for referring you: _____

Financial Information

Person responsible for financial matters: ☐Self ☐Spouse ☐Parent/Guardian Other

Insurance: ☐Yes ☐No ☐Assignment ☐Non-Assignment On Calendar Year? ☐Yes ☐No If no, Insurance year ends?_____

INSURANCE INFORMATION

Insurance Company_____ Name of Policy Holder: _____

Employer of Policy Holder:_____ Date of Birth Policy Holder: _____/_____/_____
DD MM YYYY

Policy #:_____Certificate /ID#:_____

Coverage Maximum_____% Coverage for basic work _____% Coverage for major work _____ Orthodontic ☐Yes or ☐No

Non-Assignment Insurance

All patients are responsible for the payment of their own account. Payment in full is expected at the end of each treatment

Assignment Insurance

All patients are responsible for the payment of their own account. Please remember that insurance is considered a method of reimbursement for the fees owed to the doctor and is NOT a substitute for payment. Some companies' pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company. For those insurance that allow for assignment should we not receive payment within 30 days of the service date the full amount of the invoice will be your responsibility.

Your signature is an acknowledgement of your (i) financial responsibility for all charges (ii) authorization release to the dental benefits plan administrator and the CDA. It also states that you have read the above terms and agree to what is stated.

_____

Signature ☐Patient ☐Parent ☐Guardian Print Name Date (DD/MM/YYYY)

PLEASE NOTE THAT DUE TO THE PRIVACY ACT WE NO LONGER HAVE ACCESS TO OUR PATIENTS DENTAL INSURANCE INFORMATION, THEREFORE, IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH ALL INSURANCE INFORMATION.

Medical History (This information will remain confidential) Date (DD/MM/YYYY)_____

1. Are you presently being treated for any medical condition of have you been treated in the past year? ☐Yes ☐No If so, explain.

_____

2. When was your last medical check-up?_____

3. Have you ever been hospitalized for any illness or for an operation? ☐Yes ☐No If so, explain.

_____

4. Are you currently taking any prescription, non-prescription or herbal medicines? ☐Yes ☐No

A)_____ Reason_____

B)_____ Reason_____

C)_____ Reason_____

5. Have you ever had an adverse effect to any medicines? ☐Yes ☐No

☐Antibiotics (i.e. Penicillin) ☐Sulfonamide ☐Codeine ☐Local Anesthetic

☐Aspirin ☐Injections ☐Others specify_____

6. Have you ever been advised by your doctor to take Antibiotics before having dental treatment? ☐Yes ☐No

7. Have you ever taken prolonged medical or non-medical drugs? ☐Yes ☐No If so, which? _____

8. Do you suffer from any medicinal or environmental allergies (hay fever, latex etc.)? ☐Yes ☐No If so, which?_____

9. Do you bruise easily or have prolonged bleeding? ☐Yes ☐No If so, which?_____

10. Do you have a heart murmur, rheumatic fever or mitral valve prolapse? ☐Yes ☐No If so, which?_____

11. Do you have an immune compromise condition i.e. HIV, AIDS, Radiotherapy, or Chemotherapy? ☐Yes ☐No If so, which?_____

12. Have you ever had Jaundice, Hepatitis A, B, or C or Liver Disease? ☐Yes ☐No If so, which?_____

13. Do you have a family history of health conditions viz. Diabetes. Cancer or Heart Disease? ☐Yes ☐No If so, which?_____

14. Do you have or ever had Asthma? ☐Yes ☐No

15. Have you ever fainted, had shortness of breath or chest pain? ☐Yes ☐No If so, which?_____

16. Have you ever had any artificial joint replacement or heart valve replacement? ☐Yes ☐No If so, when?_____

17. **WOMEN** are you pregnant or breast feeding or using birth control? ☐Yes ☐No Reached menopause? ☐Yes ☐No

18. Do you have or have you ever had any of the following? Please ✓ appropriate boxes NONE ☐ _____(initials)

☐Chest pain	☐Shortness of breath	☐Pacemaker	☐Steroid therapy	☐High blood pressure
☐Seizures	☐Drug/Alcohol dependency	☐Heart Attack	☐Lung disease	
☐Diabetes	☐Kidney disease	☐Stroke	☐Prosthetic heart valve	
☐Tuberculosis	☐Stomach Ulcers	☐Thyroid Disease	☐Cancer	
☐Arthritis	☐diet pill therapy	☐Eating disorder	☐Low Blood Pressure	

19. Are there any conditions or diseases not listed above that you have ever had? ☐Yes ☐No If so, what?

Dental History

1. What is the reason for today's visit? ☐Emergency ☐Examination ☐Other_____

2. How frequently do you see a dentist? ☐3-6 month's ☐Annually ☐Other_____

3. How often do you brush per day? _____ Floss?_____ Use Anti-bacterial rinse?_____

4. Do your gums feel swollen or tender? ☐Yes ☐No If so, what?_____

5. Do your jaws hurt, crack, pop or grate when you open widely? ☐Yes ☐No If so, what?_____

6. Do you have bad breath or a bad taste in your mouth? ☐Yes ☐No If so, what?_____

7. Have you ever had any problems with previous dental treatments? Specify_____

8. Patient Concerns: ☐Time ☐Money ☐Insurance ☐Esthetics ☐Discomfort ☐Tooth Loss

9. Describe in words what would you would like done with your teeth._____

10. Are you tense during dental visits? ☐A little ☐Moderately ☐Very tense ☐Would prefer to be sedated

11. Do you smoke? ☐Yes ☐No If so, How many per day?_____How long have you been smoking?_____

General Consent Statement

I certify that I have read, understood and accurately completed the personal, medical and dental histories, to the best of my knowledge, and have not knowingly omitted any information. I consent to the release of medical information from my medical or other health care provider as required by this dental office. I authorize Dr. Beena George Dentistry to perform diagnostic procedures as may be required to determine necessary dental treatment. I understand that Dr. Beena George Dentistry requires a minimum of 2 business days notice for any appointment cancellation otherwise I will be charged a cancellation fee.

_____

Signature ☐Patient ☐Parent ☐Guardian Print Name Date (DD/MM/YYYY)