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Phone: **(905) 884-6633** Fax: **(905) 884-6677**

Dr. Kiran Mathur B.Sc., B.D.S
Dr. Sanjay Mathur B.D.S

Welcome to our dental office. We look forward to becoming partners in your dental health care. Our dentistry is prevention oriented and it is team effort involving you and our staff. Together we will address any current dental concern and endeavor to prevent future dental problems. Your cooperation in completing the questionnaire is essential to provide you with the highest standard of dental care. All the information is strictly confidential and will remain with the office in compliance with the regulations of the Royal College of Dental Surgeons. If you have any questions we will be glad to assist you.

Patient Information (PLEASE PRINT CLEARLY):

Date: ______________________

Last Name:____________________________ First Name:______________________________

Sex: Male ☐ Female ☐ D.O.B (dd/mm/yy): _______________ Age:____________

Marital Status: _______________ Health card #: ___________________________________

Address: _____________________________ Apt#:_____ City: _______________________

Province: ____________ Postal Code: __________ How long at this address:________________

Home # :( )_____-_____ Work # :( )_____-______ext:_____ Cell# :( )_____-_______

Occupation:____________________ Employer:_________________ # of years employed:_______

Relationship to patient (dependent under 18 years) Full Name:____________________________

Reason for this visit: ____

Email Address: ____

Who may we thank for referring you to our office? _______________________________________

Emergency Contact Information- Relative that is NOT living with you:

Full Name:_____________________________ Relationship:____________________________

Home #: (____) _____-________ Work #:(_____)_____-________ Cell # (_____)______-_________

Dental Insurance(s) Information:

PRIMARY:

Member's Full Name:_______________

Date of Birth (dd/mm/yy): ____________

Insurance Company: ________________

Employer:________________________

Policy/Group #:____________________

Certificate/ID #: ___________________

SECONDARY:

Member's Full Name:_______________

Date of Birth (dd/mm/yy): ____________

Insurance Company:_________________

Employer: _______________________

Policy/Group #:____________________

Certificate/ID #: ___________________

DENTAL HISTORY	YES /NO
How long since you have seen a dentist?	
Last COMPLETE dental exam, date:	
Last full mouth X-RAYS, date:	
Are you having any problems now? If so, what are they?	
Do your gums BLEED, feel TENDER or IRRITATED? (circle)	
Are your teeth sensitive to hot, cold, sweets, pressure? (circle)	
Are you aware of grinding or clenching your teeth?	
Have you worn braces on your teeth?	
Do you currently or have a history of headaches, jaw pain, neck pain?	

Family Physician: ______________________________

Phone number: ______________________________

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Responsibility & Consent

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to help me understand the nature of the enquiries listed in this form and was able to answer them thoroughly and truthfully. Should there be any changes in my health status in the future, I will advise City Heart Dental. I authorize the Dentist to perform diagnostic procedures, as required to determine the necessary treatment and, I consent to the release of medical-dental information from previous/present health/dental care providers to City Heart Dental office as deemed necessary. I understand that I am fully responsible for the payments pertaining to all dental services provided to me and my dependents and, any fees due are payable at the time services are rendered.

Patient Signature (Parent of child): ______________________

Office Signature: ______________________

Date: ______________________

MEDICAL HISTORY	*YES/NO*
Do you have any health problems?	
Are you currently under a Physicians care? If so, for what reason?	
What medications are you taking?	
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	
For Women: Are you taking birth control pills? Are you pregnant?	

Have you ever been diagnosed with or treated for any of the following conditions? (Check all that apply)

- ☐ Aids/HIV Positive
- ☐ Diabetes type1
- ☐ Diabetes type2
- ☐ Heart Surgery
- ☐ Heart Problems
- ☐ Artificial Heart Valves
- ☐ Stent insertion
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Joint replacement
- ☐ Chemotherapy
- ☐ Stroke
- ☐ Hepatitis A/B/C (circle)
- ☐ Fainting
- ☐ Ulcer/Colitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Psychiatric care
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Murmur
- ☐ Mitral Valve
- ☐ Tuberculosis
- ☐ Heart Problems
- ☐ Respiratory disease
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Radiation Treatment
- ☐ Glaucoma
- ☐ Epilepsy
- ☐ Thyroid Malfunction
- ☐ Headaches
- ☐ Jaw Pain
- ☐ Herpes
- ☐ Anxiety

Are you allergic to or have you ever reacted adversely to any of the following medications?

Aspirin
Erythromycin
Nitrous oxide
Ibuprofen (Advil)
Local Anesthetic
Latex
Codeine
Penicillin

Are you aware of being allergic to any other medications or substances? (i.e. food, materials) If yes, please list: