st andrews DENTAL

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dentist@standrewsdental.com www.standrewsdental.com

Get Acquainted Questionnaire

In order that we may better serve you, please fill in the following information:

Name _____ ❑ Mr ❑ Mrs ❑ Miss Date of Birth _____
Last First Middle

Residence _____
Street Apt. City Postal Code

Employer _____ Occupation _____

Residence Tel. # _____ Business Tel. # _____ Cell # _____

Email _____

Social Insurance No. _____ Drivers Licence No. _____

Whom may we thank for referring you to our office? _____

Person to contact in the event of an emergency:

Name _____ Relationship to patient _____

Address _____

Residence Tel. # _____ Business Tel. # _____ Cell # _____

Your Health History

Physician _____ Address _____ Tel. # _____

Date of last complete medical examination _____

Under medical treatment now or within last year _____

Hospitalized or any serious illness _____

Please indicate if you have had any of the following. If Yes please fill in details.

❑ Yes ❑ No Heart Trouble? _____

❑ Yes ❑ No Do you have pain in your chest/shortness of breath after mild exertion? _____

Please turn over→

❑ Yes ❑ No Do your ankles swell? _____

❑ Yes ❑ No Rheumatic fever or heart murmur? _____

❑ Yes ❑ No Congenital heart lesions? _____

❑ Yes ❑ No Diabetes? _____

❑ Yes ❑ No Hepatitis? _____

❑ Yes ❑ No Kidney trouble? _____

❑ Yes ❑ No Blood disorders? _____

❑ Yes ❑ No Does your occupation or social environment put you in jeopardy of contracting venereal disease, herpes or the AIDS virus? _____

❑ Yes ❑ No Epilepsy? _____

❑ Yes ❑ No Convulsions? _____

❑ Yes ❑ No Fainting? _____

❑ Yes ❑ No Gastrointestinal disorders? _____

❑ Yes ❑ No Tuberculosis/lung disease? _____

❑ Yes ❑ No Arthritis/Joint replacement? _____

❑ Yes ❑ No Stroke? _____

❑ Yes ❑ No Allergies (hay fever, rash, asthma)? _____

❑ Yes ❑ No Physical or psychological disabilities or conditions? _____

❑ Yes ❑ No Snoring/sleep apnea/sleep disturbances? _____

❑ Yes ❑ No Drug/alcohol addiction? _____

❑ Yes ❑ No Using any medicine or herbal remedies (pills, tablets, shots, drops, ointments, birth control pills, insulin, anticoagulant, cortisone, aspirin)? _____

Allergic to or any unusual reaction to:

❑ Novacaine/dental anaesthetics _____ ❑ Codeine _____

❑ Penicillin/antibiotics _____ ❑ Aspirin _____

❑ Sulfa _____ ❑ Tranquilizers _____

❑ Other _____

❑ Any illness treated by radiation therapy/chemotherapy? ❑ Any Osteoporosis medications taken?

❑ Are you pregnant now? _____ Due Date? _____

❑ Do you smoke? _____ Amount _____

Blood Pressure: _____ Date _____

Your Dental Health History

Who was your last dentist? _____ For how long? _____

When was your last dental appointment? _____ (dd/mm/yyyy) Date teeth were last cleaned? _____ (dd/mm/yyyy)

What dental treatment was completed? _____

❑ Yes ❑ No Have you had dental x-rays in the last year? _____

❑ Yes ❑ No Do you have areas of your gums that bleed easily? _____

❑ Yes ❑ No Have you ever had abnormal bleeding associated with extractions? _____

❑ Yes ❑ No Do you have frequent cold sores or canker sores? _____

❑ Yes ❑ No Is any part of your mouth sensitive to temperature or pressure? _____

❑ Yes ❑ No Have you ever had gum (periodontal treatment)? When? _____

❑ Yes ❑ No Have you ever worn braces to straighten your teeth? _____

❑ Yes ❑ No Do you clench or grind your teeth during the day or night? _____

❑ Yes ❑ No Do you ever have migraine headaches? _____

❑ Yes ❑ No Have you ever had implant surgery in one or both of your jaw joints? If you answered "yes", who performed the surgery and when was it done? _____

❑ Yes ❑ No Are you being followed-up by a dental specialist? _____

If you are wearing a partial or complete denture, please complete the following:

For what reason were the teeth lost? _____

Approximate date of extractions? _____

Has your denture been relined? _____ When? _____

How old is your present appliance? Upper _____ Lower _____

Are you satisfied with appearance? _____ Comfort? _____

Why are you seeking dental care at this time? _____

_____

Do you feel that your dental problems are serious? _____

_____

Are you happy with the appearance of your teeth? If not, why? _____

_____

What are your sports interests, general interests or hobbies? _____

_____

Please turn over→

FINANCIAL POLICY

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment: **VISA, Master Card, AMEX, Debit.**
Please be advised payment is due the day of service.

We will, as a **courtesy**, process your insurance benefits in our office, which will relieve you of this time consuming and sometimes complicated task.

PREPAYMENT: We are happy to offer a 5% discount for services over $1,000.00 when prepaid in full upon scheduling your appointment.

I agree that I am fully responsible for the total payment of all procedures performed in this office - this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that all services are due and payable at the time services are rendered, regardless of whether or not my insurance benefits have been received. One and one-half percent (1.5%) per month interest (18% per year) will be charged on accounts 60 days from treatment date.

MISSED APPOINTMENTS

Appointment times are reserved especially for you. 95% of our patients provide us with 2 business days notice to reschedule their appointments. If for any reason you should need to change your appointment, there will be no charge with 2 business days notice. Appointments changed or cancelled with less than 2 business days notice may be subject to a cancellation fee of $75 for each ½ hour of hygiene time and $150 for each ½ hour of Doctor time. Please help us serve you better by keeping the appointments you have scheduled. Our goal is to make sure you have an outstanding experience.

Signature (Responsible Party) Financial Coordinator Date

Dentist Signature Date