



**Patient Information**

Name: \_\_\_\_\_

Miss Ms. Mrs. Mr. Dr.

Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_

\_\_\_\_\_  
City Province Postal Code

Home phone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Birth Date (MM/DD/YR): \_\_\_\_\_

Male: Female:

Employer/School: \_\_\_\_\_

Occupation: \_\_\_\_\_

Email Address: \_\_\_\_\_

SIN Number: \_\_\_\_\_

Best Contact Method: Home: Work: Cell: Email: Text Msg:

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**How did you first hear about us?** Office sign Blvd Sign Yellow Pages Internet Radio Post Card

Friend Family Member Who may we thank for referring you? \_\_\_\_\_

**Insurance Information**

Cleaning Frequency: 6 months 9 months 1 year Unsure  
Do you have any coverage under First Canadian Health Social Assistance

**Primary:**

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

Date of Birth: \_\_\_\_\_

Relationship to subscriber: self spouse dependant

common-law other

Insurance Company: \_\_\_\_\_

Policy/Plan Number: \_\_\_\_\_

ID/Certificate Number: \_\_\_\_\_

**Secondary:**

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

Date of Birth: \_\_\_\_\_

Relationship to subscriber: self spouse dependant

common-law other

Insurance Company: \_\_\_\_\_

Policy/Plan Number: \_\_\_\_\_

ID/Certificate Number: \_\_\_\_\_

**Medical History**

Are you presently under medical treatment? Yes No Reason: \_\_\_\_\_

Are you presently taking any medication? Yes No Which medications? \_\_\_\_\_

Are you happy with your smile? Yes No

Are you nervous about dental treatment? Yes No

We offer Sleep Dentistry with IV Sedation, would this be something that interests you? Yes No

Have you ever been treated for any of the following? (please circle where applicable)

- |              |                       |                               |
|--------------|-----------------------|-------------------------------|
| Diabetes     | Hepatitis A B C D     | Heart Condition               |
| Epilepsy     | Asthma                | High / Low Blood Pressure     |
| H.I.V.       | Cancer                | Contagious Disease            |
| Thyroid      | Artificial Joints     | Headaches/TMJ issues          |
| Stroke       | Rheumatic Fever       | Emotional or Nervous Disorder |
| Heart Murmur | Mitral Valve Prolapse | Other: _____                  |

**Medical History cont'd**

**Do you have a Latex Allergy**      Yes      No  
Do you have any other allergies?    Yes      No      To what? \_\_\_\_\_  
Do you smoke?                              Yes      No  
Have you gained/lost weight recently? (Please circle where applicable)    Yes      No  
Do you snore, gasp or stop breathing? (Please circle where applicable)    Yes      No      Unsure  
Have you ever had any major operations or illness?    Yes                      No

What/When: \_\_\_\_\_

Have you ever had an unusual reaction to any dental drugs or medicine (ie: Freezing, Nitrous Oxide, Other)?  
Yes      No                      To what? \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_

Have you ever experienced prolonged bleeding after a dental extraction or any other abnormal bleeding?  
Yes      No                      To what? \_\_\_\_\_

Have you ever had Nitrous Oxide or IV sedation before?    Yes      No                      For what? \_\_\_\_\_

**Women ONLY:** Are you pregnant?    Yes      No                      Date Due: \_\_\_\_\_

**Patient Privacy Consent**

**The Personal Information Protection Electronic Documents Act (PIPEDA)** regulates the collection, use, and disclosure of personal information, allowing information to be disclosed to other healthcare providers, related health professionals, laboratories, pharmacies, financial institutions, dental insurance companies, as long as the information is related to care and treatment of a patient. All staff members who come in contact with your personal information are aware of the sensitive nature of the information.

Images Dental Centre will ensure that:

1. Only necessary information is collected about you.
2. We only share your information with your consent.
3. Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols.
4. Our privacy protocols comply with the privacy legislation, standards of our regulatory body, The Manitoba Dental Association.

Patient/Parents Initial: \_\_\_\_\_

**Permit for Procedures & Office Policies**

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to by me, to be necessary or advisable, including the use of local anesthetic as indicated and I will assume payment is expected as services are rendered, unless prior financial arrangements have been made. All past due balances are subject to 2.5% interest charged monthly. All appointments are confirmed 48 hours in advance and we ask that should we not reach you personally, that you call us back to confirm your appointment. Dental appointments cancelled without 24 hours notice will be subject to a \$65 fee per hour of the appointment.

Patient/Parents Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**[www.imagesdentalcentre.com](http://www.imagesdentalcentre.com)**

**Office Use Only:**

*I reviewed the entire chart, including the medical/dental information for this patient.*      Staff initials: \_\_\_\_\_      Date: \_\_\_\_\_