Salem
DENTAL
Caring Like Family

36 Salem Rd., Ste. A Ajax, ON L1S 7J3 T: 289-660-6066 E: info@salemdental.ca W: www.salemdental.ca

CONFIDENTIAL REGISTRATION
PATIENT INFORMATION

Name:_____ Sex:_____ Date of Birth:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

How would you like to be contacted? (please circle one) TEXT MESSAGE EMAIL PHONE (which #)_____

Marital Status:_____ Spouse Name in Full:_____ Parent Name: (If under 18):_____

Email Address:_____ Would you like email confirmations of appointments?_____

May we send you promotional emails?_____

Emergency Contact:_____ Phone Number:_____ Relationship to Patient:_____

If student, name of school:_____ Grade:_____ Who may we thank for referring you?:_____

INSURANCE INFORMATION (if applicable)

This information is used to collect insurance on your behalf.

If the insurance company refuses to pay a portion or all of the submitted expenses, I am aware that it is my responsibility to pay any amounts the insurance does not cover. _____

SIGNATURE

Policy Holder:_____ Date of Birth of Policy Holder:_____ Sex:_____
Address: (if different than patient)_____
Employer:_____ Insurance Company Name:_____
Group or Policy Number:_____ Division Number:_____ Certificate or ID Number:_____

Who is covered under this plan?_____

Do you have Secondary Insurance? If so, please complete the fields below:

Policy Holder: Date of Birth of Policy Holder: Sex:
Address: (if different then patient):_____

Employer:_____ Insurance Company Name:_____
Group or Policy Number:_____ Division:_____ Certificate or ID Number:_____

Who is covered under this plan?_____

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MEDICAL HISTORY

	YES	NO
Physician's Name:_____		
Have you ever been hospitalized for any surgical Operation or serious illness?.....	☐	☐
If yes, please explain: _____		
Are you currently taking any medication(s)?	☐	☐
If yes, please list all medications: _____ _____		

	YES	NO
Have you ever had any abnormal bleeding?....	☐	☐
Do you bruise easily?.....	☐	☐
Do you smoke or use tobacco?.....	☐	☐
WOMEN ONLY		
Are you pregnant?.....	☐	☐
Is there a possibility you could be?.....	☐	☐
Are you taking birth control pills?.....	☐	☐

Are you allergic to, or have you had reactions to:

	YES	NO
Local anesthetics?.....	☐	☐
Penicillin or other antibiotics?.....	☐	☐
Latex/Rubber?.....	☐	☐
Any other allergies not listed above? _____		

Do you have, or have you ever had the following:

	YES	NO
Heart defect or heart murmur?.....	☐	☐
Heart trouble, heart attack or angina?.....	☐	☐
High/low blood pressure?.....	☐	☐
Mental Health Care?.....	☐	☐

	YES	NO
Stroke or Transient Ischemic Attack(TIA)?.....	☐	☐
Asthma or Hay Fever?.....	☐	☐
Diabetes?.....	☐	☐
AIDS or HIV Infection?.....	☐	☐
Joint replacement or Implant?.....	☐	☐
If you answered yes, have you had an infection in the past three years in this area?.....	☐	☐
Kidney trouble?.....	☐	☐
Tuberculosis?.....	☐	☐
Chemotherapy (Cancer/Leukemia)?.....	☐	☐
Epilepsy or Seizures?.....	☐	☐

Is there any further medical information that we should know that could affect any treatment you receive with us?

_____

_____

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DENTAL HISTORY

Reason for today's visit:_____

When was your last dental visit? _____

What was this visit for?_____When was your last dental cleaning?_____

	YES	NO		YES	NO
Are your teeth sensitive to hot or cold liquids or food?	☐	☐	Have you had any head, neck or jaw injuries?	☐	☐
Do you feel any pain in any of your teeth?	☐	☐	Have you ever experienced any of the following		
Have you ever had any prolonged bleeding			problems in your jaw area?	☐	☐
following extractions?	☐	☐	Clicking.....	☐	☐
Do you have any sore or lumps in or near your mouth?	☐	☐	Pain.....	☐	☐
Do you wear dentures or partials?	☐	☐	Difficulty in opening or closing.....	☐	☐
If yes, date of replacement?	☐	☐	Do you frequent headaches?.....	☐	☐
Do you clench or grind your teeth?	☐	☐			

If you could change ANYTHING about your smile, what would you change?

Do you have any disease, condition, or problem not listed in this form that you can think of that we should know about?

Patient/Guardian/Parent Signature:_____

Print Name:_____ Date:_____

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Office Policies

We at Salem Dental, believe that clarity is the key to a good relationship. In an effort to ensure your appointments are as pleasant and predictable as possible, we would like to give you an overview of our office policies. Please feel free to call us with any questions you may have.

Insurance Billing:
Due to the Canadian Personal Privacy Act, we are unable to access any sufficient information from your insurance company regarding your dental plan. We are happy to help you with any information you need in acquiring that information such as what the phone number is, questions to ask, and what to enquire about regarding maximums, frequencies and other limitations.

Please Note:

The Dental College is currently recommending that all dental offices collect fee for service at each appointment. This is due to the large amount of insurance companies refusing to pay the offices directly. If your plan is one of those set up to only reimburse the policy holder, we must request that you pay us directly. We will assist you in any way we can, including sending all documentation directly to the insurance company on your behalf to expedite payment to you.

Appointment Reminders:
Please understand, that appointment reminders are a courtesy only. We attempt to contact you 1-2 days before your scheduled appointment but only to remind you of the time of your appointment. If you are unable to keep your scheduled appointment, we require 2 business days' notice and do not accept cancellations through voicemail. This is very much appreciated!

Our desire is for you to have a pleasant experience in our office. We strive to serve you to the best of our ability in helping you attain optimal dental and overall health.

I have read and understood the above policies.

Patient Name:_____

Patient/Guardian/Parent Signature:_____ Date:_____

Patient/Guardian/Parent Name:_____