Glenashton Dental Centre

333 Glenashton Dr Unit 3, Oakville, ON, L6H 7P6
905-842-5500 info@glenashtondental.ca

Welcome to Glenashton Dental Centre - Confidential Patient Information

Patient Details - Last name: | First name: | Middle name:

Today's Date: | Birth Date: | Gender: ☐ Male ☐ Female

Status: ☐ Married ☐ Single ☐ Child ☐ Other | Name of Spouse: | Names of Children:

Phone (Home): | Phone (Work): | Ext:

Best time to call: | Mobile: | Email:

Preferred appointment times:

☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Address - Street: | Apartment #:

City/Town: | Province: | Postal Code:

Health Information

Name of Previous Dentist: | Dentist Telephone Number: | Date of Last Dental Visit: | Reason for this visit:

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS / HIV
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Anorexia Nervosa
- ☐ Artificial Heart valve
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joints (hips, knees)
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Circulation Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone/steroid
- ☐ Chemotherapy/Radiation
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug/alcohol dependency
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Glandular disorder
- ☐ Growths
- ☐ Head/neck Injuries
- ☐ Heart Disease/attack
- ☐ Heart Murmur
- ☐ Heart Rhythm Disorder
- ☐ Mitral Valve Prolapse
- ☐ Migraine Headaches
- ☐ Hepatitis A/B/C
- ☐ Herpes
- ☐ High/Low Blood Pressure
- ☐ Hodgkin's disease
- ☐ Hyper/hypo Glycemia
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Leukemia
- ☐ Lung disease
- ☐ Malignant hyperthermia
- ☐ Mental/nervous disorders
- ☐ Organ transplant/implant
- ☐ Psychiatric disorder
- ☐ Pacemaker
- ☐ Recreational Drug use
- ☐ Respiratory Problems
- ☐ Rheumatic Scarlet fever
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers/Tumors
- ☐ Venereal Disease
- ☐ Sleep Apnea

FOR WOMEN ONLY:

Are you breast feeding ☐ Yes ☐ No

Are you pregnant: ☐ Yes ☐ No

Due Date:

Adverse effects to any of the following:

- ☐ Penicillin
- ☐ Sulfonamide
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Darvon
- ☐ Local Anaesthetic
- ☐ None
- ☐ Other

Allergies (hay fever, latex etc.)

Please list your Medications:

Glenashton Dental Centre

333 Glenashton Dr Unit 3, Oakville, ON, L6H 7P6
905-842-5500 info@glenashtondental.ca

Family history of adverse anesthetic outcomes ☐ No ☐ Yes
Do you have bad breath or a bad taste in your mouth? ☐ No ☐ Yes
Do your jaws crack, pop, or grate when you open widely? ☐ No ☐ Yes
Are you satisfied with your teeth? ☐ No ☐ Yes
If not,Specify_____
Have you ever had any complications following dental treatment? ☐ No ☐ Yes,
If yes, please explain: _____
Have been to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes,
If yes, please explain: _____
Are you now under the care of a physician? ☐ No ☐ Yes
If yes, Please explain: _____
Name of Physician: _____ Phone: _____
Do you have any health problems that need further clarification? _____
Do you smoke? How much per day? _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, _____

☐ Medical Walk in ☐ Yellow Pages ☐ Newsletter ☐ Road Sign ☐ Newspaper ☐ Pharmacy ☐ Other: _____

Special Concerns:

Are you nervous about dental treatment? ☐ No ☐ Yes _____
Would you like more information on tooth whitening? ☐ No ☐ Yes _____
Would you like more information on braces? ☐ No ☐ Yes _____
Are you aware of night time tooth grinding? ☐ No ☐ Yes _____
Do you require a sports mouth guard? ☐ No ☐ Yes _____

Insurance Holder's Information

Primary Insurance Plans

Name of Insured:
Is Insured a patient? ☐ No ☐ Yes
Insured's Birth Date:
ID/Cert #:
Group #:
Insurance Plan Provider:
Insured's Employer Name:
Patient's relationship to insured:
☐ Self ☐ Spouse ☐ Child
☐ Other _____

Secondary Insurance Plans

Name of Insured:
Is Insured a patient? ☐ No ☐ Yes
Insured's Birth Date:
ID/Cert #:
Group #:
Insurance Plan Provider:
Insured's Employer Name:
Patient's relationship to insured:
☐ Self ☐ Spouse ☐ Child
☐ Other _____

Glenashton Dental Centre

333 Glenashton Dr Unit 3, Oakville, ON, L6H 7P6
905-842-5500 info@glenashtondental.ca

Financial Polices

Your insurance benefits are between you, your employer and your insurance company. Any benefit difference (deductible, fee guide, ineligible service or co-payment) is your responsibility.
A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.
All estimates for approximate.

Privacy act:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. I understand that Glenashton Dental Office has a privacy act & will take the steps to protect my information. I know that your office has a Privacy Code, and I can ask to see the code at any time. I agree that Dr.Harbans Singh Bamrah/ Glenashton Dental Centre can collect use and disclose personal information about myself as set out in the privacy act. I hereby assign my benefits, payable from claims submitted electronically to Dr. Harbans S. Bamrah and authorize payment directly to him/her. This authorization shall continue in effect until the undersigned revokes the same.

General Release

I, the undersigned, certify that all of the information I have completed is correct and that I have not knowingly omitted data. I understand that the information contained in the medical and dental history is important to my treatment and if I ever have any change in my health, I will inform the doctors at the next appointment without fail. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my treatment or dental diagnostic procedures. I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, guardian, or guarantor of payments

Date

Printed Name of patient, parent, guardian, or guarantor

Dentist Signature