Welcome

To the office of Dr.Foresto Dentistry

3850 Dougall Ave. - Unit 3, Windsor, Ontario N9G 1X2
519-972-6148

PATIENT INFORMATION

The patient is an : **ADULT** ❑ **CHILD** ❑ NAME UNDER GUARDIANSHIP:____________________

NAME:______________________________________ Dr. Mr. Mrs. Ms.
Preferred name to be called: ________________________

ADDRESS:____
(STREET) (CITY) (PROVINCE) (POSTAL CODE)

HOME PHONE:( ) __________________ S.I.N.________________________
BUS. PHONE : ( ) __________________ Ext.______ May we call you at work YES NO
Employer/Occupation:____
Date of birth :______________ Age:___Sex:___ Marital status:_____ Name of spouse:_________
M D Y Are other family members patients at this office?______________

Whom may we thank for referring you?______________________________________

Reason for today's visit: Annual Exam ___ Emergency ___ Other:____________________

Children Only: School_________________________ Grade:____Favorite toy/sport:______________

Brothers/Sisters:____

MEDICAL PRIORITY

Family Physician:__________________________________ Phone: (___)____________
Medical Specialist:_________________________________ Phone: (___)____________
In Case of an Emergency, please contact:_____________________ Phone: (___)____________

FINANCIAL INFORMATION

I have read over the office financial policy and understand my financial responsibilities. I understand that I am responsible for payment of dental services for myself and my dependents, which are due and payable at the time services are rendered, unless financial arrangements including insurance or otherwise have been made.

Method of Payment : Cash ❑ Debit Card ❑ Visa ❑ Master Card ❑

Responsible Party's Signature:__________________________ **Date:**______________

DENTAL INSURANCE INFORMATION		SECONDARY DENTAL INSURANCE	
Name of Subscriber		Name of Subscriber	
Date of Birth	Ins. yr. end	Date of Birth	Ins. Yr. end
Emp./Grp. Policy Holder		Emp./Grp. Policy Holder	
Ins. Co.	Max Coverage:	Ins. Co.	Max coverage:
Grp./Ind. Policy #	Cert. #	Grp./Ind. Policy #	Cert. #

The fees charged for dental services provided at this office are in accordance with the current Ontario Dental Association fee guide.
Dental Services provided by Dr. Foresto Dentistry Professional Corporation and Hygiene Services provided by Foresto Inc.

MEDICAL HISTORY

1. Have you been under the care of a physician in the last year..YES NO

   Why?____

2. Have you been hospitalized within the last five years?.. YES NO

   Why?____

3. Are you allergic or have you ever had a bad reaction to any of the following drugs(circle)

   none penicillin local anaesthetic nitrous oxide aspirin codeine latex

   any other____

4. List any medication you are taking ____

5. **Circle** any of the following which you have had or have at the present.

Rheumatic Fever	Hepatitis A B C ______	Asthma	Abnormal Bleeding
Heart Murmur/ Mitral Valve Prolapse	Tuberculosis	Epilepsy/Seizures	Ulcers
High Blood Pressure	AIDS/ HIV +	Diabetes	Liver Disease
Artificial Heart Valve	Cancer	Thyroid Disease	Jaundice
Stroke	Chemotherapy	Arthritis	Psychiatric treatment
Heart Disease	Glaucoma	Drug Abuse	Alcohol Abuse
Angina	Weight Loss	Nervousness	Kidney Disease
Heart Failure/ Attack	Malignant Hypothermia	Cold Sores	Head and Neck radiation

Do you have or had any disease, condition or problem no listed?____

6. Women only: Are you pregnant YES Expected delivery date______________ Breast feeding ________

   If NO, are you taking birth control pills YES NO

DENTAL HISTORY

Previous Dentist____________________________ Date of your last dental visit__________________

Date of last cleaning______________________

1. Circle if you have ever had Orthodontic, Oral Appliance, Periodontal, or Oral surgery.________________

2..Do you have any dental pain...YES NO

3..Do you have bleeding gums?...YES NO

4.Do you smoke ....NO YES How much?...

5. Does food get stuck between your teeth...YES NO

6. Are any of your teeth sensitive to heat, cold, sweets or pressure? ....YES NO

7. Does your jaw click, pop or get locked...YES NO

8.Are you under more than average stress lately?..YES NO

9.Do you have difficulty in opening or closing your mouth?...YES NO

10.Do you experience any pain around your ear or side of your face?..................................YES NO

11. Are there any growths or sore spots in your mouth?...YES NO

12. Are you happy with the appearance of your teeth?...YES NO

   If NO Why?____

GENERAL RELEASE 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 any questions regarding this form. **Should there be any change in either my health status or any other information I have provided I will advise this dental office.** I authorize the dentist to preform diagnostic procedures as may be require to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and give my consent to my personal information being collected, used and disclosed within the guidelines of the policy, which complies with the Personal Information and Protection and Electronic Documents Act.

Authorized Signature______________________________Date__________________ Patient Parent Guardian