LAWSON DENTAL

Patient Information

Welcome to our office. Please take a moment to enter your information. All information is confidential.

Patient Name: _____
Last First MI Preferred Name

Title: _____(Mr/Ms/Mrs/Dr/etc) **Gender:** Male/Female (please circle)

Family Status: _____(Married/Single/Child/Other) **Sask. Hosp. No.** _____

Birthdate: _____ (DD/MM/YYYY)

Mailing Address: _____

City: _____ **Prov:** _____ **Postal Code:** _____

Home Phone:_____ **Work Phone:** _____**Ext** _____

Cell Phone: _____

Email Address: _____

Do you authorize us to communicate with you through electronic means? ◯ Yes ◯ No

Your Employer: _____ **Occupation:** _____

Spouse's Name: _____ **Occupation/Employer:** _____

If the patient is a minor, or unable to provide consent, who is legally responsible?

Name: _____ **Relationship:** _____ **Phone No:** _____

Whom may we thank for referring you to our practice? Please check all that apply.

☐ Friends/Family ☐ Dental Office ☐ GymTV
☐ Facebook ☐ Google ☐ Website
☐ Location/Driving By ☐ Billboard Sign ☐ Other (List below):

Name of person, office, or other source referring you to our practice: _____

What is your immediate dental concern? _____

When was your last check up? _____ **Last Cleaning?** _____

What is the name of your previous dentist? _____

Were x-rays taken there in the past year? Yes ◯ No ◯

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Office Policy for Services Rendered

Payment is expected when services are rendered unless other arrangements are made in advance.

Dental Coverage: Yes ◯ No ◯

Private/Employer Plan ◯ Family Income Plan/Supplementary Health ◯ First Canadian Health ◯

I will pay for my portion of Dental Services with the following payment type(s):

MasterCard ◯ Visa ◯ Amex ◯ Interac ◯ Cash ◯ Cheque ◯

Do you authorize electronic processing to your insurance company? Yes ◯ No ◯

Patient Certification and Consent

As we provide your dental care, we are required to record and maintain your medical history, current condition, treatment plan and all care given. Whether this information is stored in writing, on our computer, or by other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality. Your personal information is important to us and other health care professionals involved in your care.

I, _____, acknowledge that The College of Dental Surgeons of Saskatchewan Privacy Policy was available for me to read (on the reception desk) and I understand my rights with respect to my personal information. I further consent to the collection, use and disclosure of my personal information for the following purposes:

- To provide me with dental health services;
- To maintain communications and provide me with information and follow-up respecting my dental care;
- To obtain payment of my account;
- For the uses, purposes and disclosures described in the Privacy Policy;
- To forward any dental records and information as requested by myself to another provider.

I, the undersigned, certify that all of the above information is true to my knowledge and I have not omitted any pertinent information. I understand that there can be rare occurrences of complications with local anesthetics which include prolonged numbness, bruising or a temporary increase in heart rate. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable including the use of local anesthetic as indicated. I will assume responsibility for fees associated with all procedures.

Patient (Parent, Guardian) Signature: _____ **Date:** _____

LAWSON DENTAL

Medical Health

Your answers are important. Please help us to diagnose conditions completely, so that we may give the safest treatment and most personal attention. All information is confidential.

Patient Name: _____

1. General Health (please check): Excellent ◯ Good ◯ Fair ◯ Poor ◯
2. Name of Physician: _____
3. Last complete physical: _____
4. Are you taking medication now? Yes ◯ No ◯
   Name of Medication: _____
   For what purpose? _____
   _____
5. Do you have or have you ever been treated for: (check all that apply)

☐ Heart Disease	☐ Heart Attack	☐ High Blood Pressure
☐ Pacemaker	☐ Joint Replacement	☐ Heart Valve Replacement
☐ Organ Transplant	☐ Rheumatic Fever	☐ Congenital Heart Lesions
☐ Asthma	☐ Ulcers	☐ Diabetes
☐ Sinus Trouble	☐ Stroke	☐ Tuberculosis / Lung Disease
☐ Arthritis	☐ Epilepsy	☐ Hepatitis A / B / C
☐ Cancer	☐ Anemia	☐ AIDS / HIV Positive
☐ Glaucoma	☐ Mental Health Disorder	☐ Venereal Disease / STD
☐ Thyroid Disorders	☐ Hearing Disability	

6. Has it been recommended that you receive antibiotics **for medical reasons** prior to dental treatment? Yes ◯ No ◯
7. Have you experienced any unusual reactions to any of the following drugs?
   Aspirin ☐ Codeine ☐ Penicillin ☐ Erythromycin ☐ Tetracycline ☐ Sulfa ☐ Local Anesthetics ☐
   Other Medications ☐ (Please list) _____
   _____
8. Do you suffer from any other allergies? Yes ◯ No ◯
   Latex ☐ Food Colouring ☐ Metals ☐
   Other ☐ (please list) _____
9. Have you ever been treated with radiation for medical therapy? Yes ◯ No ◯
10. Are you subject to prolonged bleeding? Yes ◯ No ◯
11. Are you subject to fainting spells? Yes ◯ No ◯
12. Do you have any disease, condition or problem not listed above that you think the doctor should know about? Yes ◯ No ◯
    If Yes, What? _____
13. Do you consume tobacco products (including e-cigarettes)? Yes ◯ No ◯ if yes, amount? _____
14. Do you consume alcohol? Yes ◯ No ◯ if yes, amount? _____
15. Do you use a wheelchair? Yes ◯ No ◯
    If yes, please let us know if you transfer or if your wheelchair reclines? _____
16. (Women) Are you pregnant? Yes ◯ No ◯ if yes, due date? _____

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Dental Health

1. Do you feel your dental health is (please check): Excellent ◯ Good ◯ Fair ◯ Poor ◯
2. Are you satisfied with the appearance/colour of your teeth? Yes ◯ No ◯
3. Have you ever had an injury to the face or jaws? Yes ◯ No ◯
4. Do you clench or grind your teeth during the day or night (that you have been made aware of)? Yes ◯ No ◯
5. Do you have any problems chewing? Yes ◯ No ◯
6. Do you have loose or sensitive teeth? Yes ◯ No ◯
7. Have you had Orthodontic Treatment? (Braces) Yes ◯ No ◯
8. Have you had Periodontal Treatment? (Gums) Yes ◯ No ◯
9. Do you have clicking or "gravel-like" sounds in your jaw joint, or have you ever experienced an inability to move your jaw or open your mouth widely? Yes ◯ No ◯
10. Do you now, or have you ever had pain in your jaw joint or in the sides of your face in and about the ears? Yes ◯ No ◯
11. Which side do you normally chew on? Right ◯ Left ◯ Both ◯
12. Do you feel that you will lose your teeth and eventually have to wear full dentures? Yes ◯ No ◯
    If Yes, at what age? _____
13. Do you have difficulty swallowing? Yes ◯ No ◯
14. Do you have an unpleasant odor or taste in your mouth? Yes ◯ No ◯
15. Do your gums ever bleed? Yes ◯ No ◯

Please sign and date below

Date:_____ Signature: _____

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Patient Policy Outline

We appreciate your selection of our office to serve your dental health needs. Our goal is to provide the very best dental care for our patients so that each of you may achieve optimum dental health throughout your lifetime.

Please review the following to become more familiar with our policies.

1. Since appointments are reserved exclusively for you alone and there are many other patients waiting for treatment, we require two business days notice to reschedule an appointment or there may be a charge. We will attempt to remind you of your appointment a day or two in advance, however it is your responsibility to keep your appointments.

2. Our fees are based on the current College of Dental Surgeons of Saskatchewan Fee Guide.

3. Dental insurance can be a great benefit to you and your family but your dental plan is a contract between you, your employer, and the insurance company. Therefore, you are ultimately responsible to us for payment.

   Assignment (direct billing) of insurance benefits is accepted provided that:

   i. the applicable policy numbers are available at the time of the appointment. (We will keep your information on file for future visits.)
   ii. any fees not covered by your insurance company are paid at the time of the appointment.
   iii. your insurance company will send payment to us.

4. Fees must be paid on the day of treatment. For your convenience, we accept Interac, Visa, MasterCard, American Express, and E-transfer. Do not hesitate to discuss our fees with us if you have any questions.

We look forward to working with you to meet your dental needs. If you have any questions or concerns, please do not hesitate to discuss them with a member of our team.

April/2017

Date:_____

Signature:_____

MDR Dental Prof. Corp
201-2803 Faithfull Ave. Saskatoon, SK S7K 8E8
Tel. (306) 933-3233 Fax. (306) 931-7861