GET AQUAINTED QUESTIONNAIRE

Personal Information

Patient's Name: Mr. Mrs. Miss Ms. Master ____

How do you prefer to be addressed? ___________________ **Parent (if applicable)** ___________________

Home Address: ____

City: ________________________ **Province** ____________________________ **Postal Code** __________

Telephone: Home **(** **)**__ ___-________ Bus. **(** **)**__ ___-________ Cell. **(** **)**___ __-________

Email Address: ____

Age: _____________________ **Birth date:** ____

How did you hear about our office? ____

Have you seen us in the following: ☐ **Yellow Pages** ☐ **Newspaper Ad** ☐ **Magnet** ☐ **Mailer** ☐ **Web Site** ☐ **Sponsorship** ☐ **Other** _______________

Insurance Information

Do you have dental insurance?____ **Name of Insured:** ___________________**Insured Birth Date:** / /

Employer: ______________________**Address:**________________________________**How Long:**____**yrs**

Insurance Company:__________________Check-up frequency ☐2/year ☐6 months ☐9 months ☐12 months

Policy or Group Number:___________________**I.D. or Certificate Number:**________________________

Secondary Insurance Company:_________________________**Name of Insured:**___________________

Insured Date of Birth: / / **Employer::**______________________**Address:**__________________

Policy or Group Number:____________________**I.D. or Certificate Number:**_______________________

Dental History

Main reason for visit today:____

Date of last dental check-up:______/_____(MM/YY) **Are you nervous about seeing a Dentist?** Yes No

Name of last dentist:__________________________________**Number of years as his/her patient:**______

Why have you changed dentist?____

Have you had a complete dental exam with a full x-ray series within the last 3 years? Yes No

Are you interested in improving the appearance of your smile? Yes No **Whitening your teeth?** Yes No

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (please check if applicable)

☐ Teeth sensitive to: Cold Hot Sweets Pressure
☐ Periodontal (gum) treatment
☐ Bleeding gums – if yes, how long? __________
☐ Frequent blisters on lips or mouth
☐ Orthodontic Treatment
☐ Loose teeth
☐ Bad breath
☐ Food impaction
☐ Unpleasant taste
☐ Swelling or lumps in the mouth
☐ Clicking or sore jaw

I hereby acknowledge responsibility for all fees charged for treatment rendered whether covered by insurance or not. In addition, I understand that a fee will be charged for missed appointments by myself (or my children) where at least 48 hours notice is not provided. I also give consent (if necessary) to photographs being taken and used for illustration of my treatment. I consent to electronic submission of my dental claims to my insurance company. I also consent to your collection, of any and all personal information about me including personal health information, and all personal information about any minor of whom I have joint or sole parental custody, and to use such information in any manner or for any purpose whatsoever, but only in the course, of, concerning, or relating to, your dental practice. I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Professions, the Dentistry, and Dental Hygiene Acts of Ontario, and to any insurer or other payment organization who may be responsible for payment of all or part of any treatment or service you provide.

Patient's Signature:____**Date**______________________