Dr. Francois (Franco) Girard
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Welcome to Oaklands Dental! To get started, please tell us a little about you.

Date ____________________________________ Date of Birth ___________________________________

Last Name _______________________________First Name _____________________________________

Parent/Guardian Name (if patient is under 18 years old) ____

Gender *Male* *Female* *Other* (Note: if Other, pls note insurance usually requires identification as M or F. In this case, which shall we put for that purpose?)

Street Address ____

City ____Postal Code __________________________

Email Address ____

Preferred Phone Number ☐ Cell ☐ Home ____________________ Secondary Phone Number ☐ Cell ☐ Home ________________

Place of Employment ____

Emergency Contact Name and Phone Number ____

How did you hear about Oaklands Dental? ____
(If it was an individual, please tell us their name so we can express our appreciation!)

If you have dental insurance To enable our office to process your dental insurance claims and the electronic transfer of information, please complete the following information and sign the statements below:

Insurance Company ______________________________Group # _____________________ ID # ___________________________

Policy Holder Name ____ Policy Holder DOB __________________________

Policy Holder Place of Employment ____ Relationship to patient _______________________

Coverage Basic _____% Major _____% Plan Maximum ______ Frequency limitations____

I authorize release of information contained in claims to be submitted to my dental insurance. I also authorize the communication of information related to the services provided by Dr. Girard and his staff.

Dr. Girard will accept direct payment from my dental insurance carrier. I hereby assign my benefits, payable from claims submitted electronically by Dr. Girard and authorize payment directly to him.

*We request **advance notice of at least 2 business days** should you need to make changes to your reserved appointments to avoid short notice fees. **Please note that our office is not open on Fridays, therefore Friday does not count as a business day.*

Signature ____ Date _____________

I understand that Oaklands Dental cannot know all the details of my insurance or any changes to my plan. There is a possibility that my insurance plan may pay differently than anticipated or may not cover my treatment in full. ***I, as the patient, am responsible for any portion not covered by my insurance plan at the time of treatment.***

Signature ____ Date _____________

MEDICAL HISTORY

Physician's Name ____ Phone Number ___________________________

Women – are you pregnant? *No* *Yes* *Due Date* ____

Do you have a current medical problem or condition? *No* *Yes Details* ____________________________________

List medications you are currently taking, including those in the aspirin/ASA family & herbal supplements:

List allergies to **any** drugs, pills, medicine, latex, or other

HAVE YOU HAD ANY OF THE FOLLOWING:

YES	NO		YES	NO	
☐	☐	Joint replacement (hip, knee, other)	☐	☐	Hepatitis A, B, or C
☐	☐	Major operation	☐	☐	Thyroid issues
☐	☐	Serious injury to your neck or back	☐	☐	Diabetes
☐	☐	Anemia or blood disorder	☐	☐	HIV / AIDS
☐	☐	Heart problems or murmur	☐	☐	Epilepsy
☐	☐	Stomach, gastrointestinal	☐	☐	Kidney problems
☐	☐	Asthma or lung disorder	☐	☐	Glaucoma
☐	☐	Stroke	☐	☐	Rheumatic fever
☐	☐	Cancer (or family history of)	☐	☐	Tuberculosis
☐	☐	High blood pressure	☐	☐	Use of tobacco or cannabis products? *If so, type/frequency?*

PLEASE CHECK YES IF ANY OF THE FOLLOWING STATEMENTS APPLY TO YOU:

YES	NO	
☐	☐	Do your gums bleed?
☐	☐	Do you have frequent headaches?
☐	☐	Do you wake up with pain in the jaw?
☐	☐	Does your jaw click or pop?
☐	☐	Are you interested in whitening your teeth?
☐	☐	Are you interested in straightening your teeth?
☐	☐	Are you happy with your smile? *If no or not really, please provide any details:*
☐	☐	Do you have any current dental concerns? *If yes, please describe:*

Do you experience any anxiety or fear in relation to going to the dentist?

No *Yes* *If yes, please describe:*

Do you use or have a history of substance addiction?

No *Yes* *If yes, please describe:*

Please note that we do offer oral sedation if you wish to increase your comfort during your appointments – this is desired for some patients who have a strong gag reflex, or who experience some anxiety with dental procedures.

Patient Signature ____ *Date* ____________________

Guardian Signature ____ *Date* ____________________