

# New Patient Form



Welcome to Oaklands Dental! To get started, please tell us a little about you

First Name \*

Last Name \*

Date of Birth

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

Gender

- Male  Female  
 Other

If other, please specify:

Pls note insurance usually requires identification as M or F. In this case, which shall we put for that purpose?

Are you currently at a post-secondary institution?

- Yes  No

If yes, what is the name of that institution?

Address

City

Province

Postal Code

Email

Preferred Cell Phone #

 (\_\_\_) \_\_\_-\_\_\_\_

Preferred Home Phone #

 (\_\_\_) \_\_\_-\_\_\_\_

Place of Employment

Emergency Contact Name

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!

When did you last see a dentist?

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

Insurance Company

Group #

ID #

Policy Holder Name

Policy Holder's Date of Birth

Place of Employment

Relationship to patient

Coverage

Basic (%)

Major (%)

Plan Maximum

Frequency limitations

Consent

- 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 or manually by Dr. Girard and authorize payment directly to him. \*
- 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 as anticipated. I, as the patient, am responsible for any portion not covered by my insurance plan at the time of treatment. \*
- 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 is not considered a business day. \*

Medical History

Physician's Name

Phone Number

Women - Are you pregnant?

- Yes  No

If yes, due date:

Do you have a current medical problem or condition?

- Yes  No

If yes, please explain:

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

<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

If you take several medications may we contact your pharmacy and request a list of your current medications?

- Yes  No

Pharmacy Name

Location/Phone

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

Have you had any of the following:

Joint replacement (hip, knee, other)

Yes  No

Hepatitis A, B, or C

Yes  No

Any surgeries?

Yes  No

Details

Thyroid issues

Yes  No

Serious injury to your neck or back

Yes  No

Diabetes

Yes  No

Details

Anemia or blood disorder

Yes  No

HIV / AIDS

Yes  No

Heart problems or murmur

Yes  No

Epilepsy

Yes  No

Stomach, gastrointestinal

Yes  No

Kidney problems

Yes  No

Details

Asthma or lung disorder

Yes  No

Glaucoma

Yes  No

Stroke

Yes  No

Rheumatic fever

Yes  No

Cancer (or family history of)

Yes  No

Tuberculosis

Yes  No

High blood pressure

Yes  No

Use of tobacco, cannabis or illicit drugs?

Yes  No

Type/frequency

Please check if any of the following statements apply to you:

Do your gums bleed?

Yes  No

Do you have frequent headaches?

Yes  No

Do you wake up with pain in the jaw?

Yes  No

Does your jaw click or pop?

Yes  No

Are you interested in whitening your teeth?

Yes  No

Are you interested in straightening your teeth?

Yes  No

Are you happy with your smile?

Yes  No

Do you have any current dental concerns?

Yes  No

If yes, please describe

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

Yes  No

If yes, please describe:

Do you use or have a history of problematic substance use? (drugs, alcohol, other, etc.)

Yes  No

If yes, please describe:

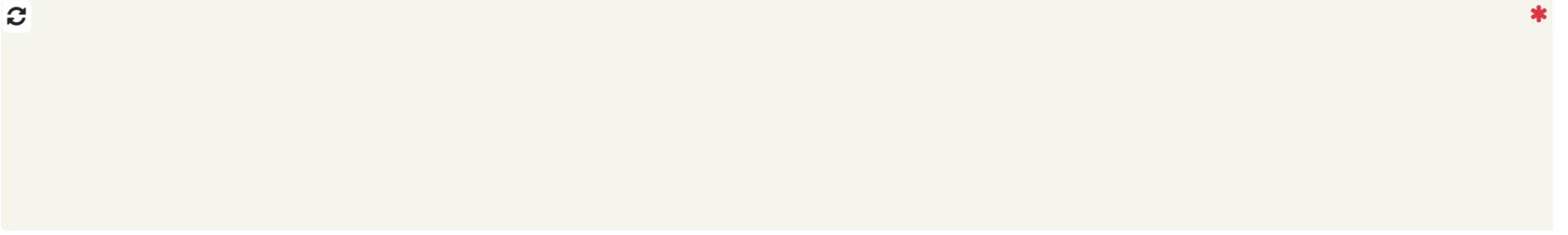
Please note that we do offer oral sedation if you wish to increase your comfort during your appointments – this is desired for some patients who have a strong gag reflex, or who experience some anxiety with dental procedures.

Name and Email of Signing person

First & Last Name \*

Email Address \*

Signature \*



Sign above

Submit