Welcome to Yonge Eglinton Periodontics. To help us provide you with the highest quality care, please complete both pages of this form.

YONGE EGLINTON
PERIODONTICS
■ PERIODONTICS AND IMPLANT SURGERY

Today's date _____

personal information

Your Name ☐Dr. ☐Mrs. ☐Mr. ☐Ms. _____ Date of birth _____

Preferred Name _____

Home address _____ City _____ Postal _____

Home phone _____ Cell phone _____ Work phone _____

Email _____ Occupation _____

Preferred contact number and method _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

insurance information

☐ I do not have insurance.

Insurance Company _____

Policy Holder's name _____

Date of birth of policy holder _____

Employer's name _____

Policy number _____

Certificate number _____

SECONDARY Insurance Company _____

Policy Holder's name _____

Date of birth of policy holder _____

Employer's name _____

Policy number _____

Certificate number _____

medical history

Please check if you have had any of the following:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia/ Blood disease
- ☐ Arthritis
- ☐ Artificial joints/replacement
- ☐ Asthma
- ☐ Cancer/Chemotherapy
- ☐ Chest pains/Angina
- ☐ Circulatory problems
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug addiction
- ☐ Emphysema
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart conditions
- ☐ Heart surgery
- ☐ Heart murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High/Low blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Jaundice
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Nervousness/mental disorders
- ☐ Osteoperosis medications
- ☐ Pacemaker
- ☐ Respiratory problems
- ☐ Rheumatic/Scarlet fever
- ☐ Seizures/Epilepsy
- ☐ Skin rash
- ☐ Steroid therapy
- ☐ Stroke
- ☐ Stomach/intestinal problems
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease

When was your last physical? _____

Are you currently taking any medications, non-prescription drugs, vitamins, or herbal supplements? If so, please list.

_____

_____

_____

Have you ever had an adverse reaction to any of the following drugs?

- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Penicillin
- ☐ Local anesthetic
- ☐ Other _____

medical history (con't)

Are you currently seeing a specialist? If yes, for what?

_____

In the last year, have you been treated for any medical conditions?

_____

Do you smoke? If so, how many per day? How many years?

_____

Have you ever had a blood transfusion? If so, when?

_____

For women:

Are you pregnant? If so, what month are you in?

_____

Are you nursing?

_____

Are you taking birth control pills?

_____

dental history

Do you have or have you had any of the following?

- Looseness of teeth ☐
- Bleeding during brushing or flossing ☐
- Spontaneous bleeding from your gums ☐
- Teeth grinding, clenching, nail biting ☐
- Sensitivity to hot or cold ☐
- Spacing between your teeth ☐
- A bad taste or smell in your mouth ☐
- Past orthodontic treatment ☐
- Future orthordontic treatment ☐
- A history of treatment for your gums ☐
- Jaw pain ☐
- Other _____ ☐

your doctor and general dentist

Name of your general dentist _____

General dentist's tel # _____

Name of your physician _____

Physician's tel # _____

It is my responsibility to inform the dental office of Dr. Kay of any changes to my medical health. I authorize the dental staff to consult with my physician if there are any concerns regarding my medical health. I also authorize the dental staff to perform any necessary dental services during diagnosis and treatment with my informed consent.

I have reviewed the patient consent form for collection, use and disclosure of personal information. It explains how Andrew Kay Dentistry Professional Corporation will use my personal information and the steps being taken to protect my information. I know that the office has a privacy code and that I can ask to see the code at any time. I agree that the practice can collect, use and disclose personal information about (patient's name) _____ as set out in the office privacy policy. I authorize release to my insurance company or plan administrator of the information in claims submitted.

_____ _____

Signature of patient, parent or guardian | Printed name of patient, parent or guardian

_____ _____

Date | Witness

We are required to collect the following information in accordance with Ontario's Narcotics Safety and Awareness Act, 2010. The Ministry of Health and Long term Care (MOHLTC) requires this information to monitor prescription narcotics and other controlled substances. Please provide one of the following approved forms of identification and record the identification number in the space provided. Approved forms of patient identification include:

Ontario Health Card or other health cards issued by a Province or Territory in Canada: _____

OR

Valid Drivers License or Temporary Diver's License: _____