Clearview Endodontics

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Initial Patient Form:

OHIP#(Health Card): ____________________

Reason for Visit: ____________________

Name: ____________________
FIRST LAST

Age: ________ DOB: ____ / ____ / ______ Sex: M F
MM DD YYYY

Address: ____________________

City: ____________________ Postal Code: ____________

Home Phone: ____________________ Other: ____________________

Email Address: ____________________ Referring Dentist: ____________________

Family Physician: ____________________ Family Dentist: ____________________

In case of Emergency please notify: ____________________ Phone: ____________

Relation: ____________

Do you have dental insurance: ☐ No ☐ Yes (If yes please provide the following information)

Primary Dental Insurance:

Insurance Company / Employer

Name of Policy Holder

Date of Birth

Relation to Patient

Group Number

Patient ID Number

Secondary Dental Insurance:

Insurance Company / Employer

Name of Policy Holder

Date of Birth

Relation to Patient

Group Number

Patient ID Number

IMPORTANT: On day of procedure with General Anaesthetic or Intravenous Sedation, you must be accompanied by an adult and they must remain in the office for the **COMPLETE VISIT.**

FEES: OHIP does not cover office procedures: **DENTAL INSURANCE MAY NOT COVER THE TOTAL FEE.** Full payment is required the day services are rendered. Please note that the financial obligation is between you and this office.

Are you in good health: ☐ Yes ☐ No

Are you under the care of a physician for any medical condition within the last 2 yrs? ☐ Yes ☐ No

If yes, please explain: ____________________

Are you pregnant (if applicable): ☐ Yes ☐ No

Have you ever been hospitalized? Explain: ____________________ ☐ Yes ☐ No

Have you recently, or are you presently, taking any PRESCRIPTION or NONPRESCRIPTION DRUGS:

1. ____________ 2. ____________ 3. ____________

4. ____________ 5. ____________ 6. ____________

7. ____________ 8. ____________ 9. ____________

Are you allergic to any medications, foods or latex? ☐ Yes ☐ No

If yes, please list: ____________________

Do you have an artificial joint of any kind? ☐ Yes ☐ No

If yes, please explain: ____________________

Are you HIV Positive or have AIDS? Explain ____________________ ☐ Yes ☐ No

Have you ever had surgery? ☐ Yes ☐ No

If yes, please list: ____________________

Do you smoke or use other forms of tobacco? ☐ Yes ☐ No

If yes, please list: ____________________

Other medical conditions? Explain: ____________________ ☐ Yes ☐ No

HAVE YOU HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Anemia	☐	☐	Intestinal Problems	☐	☐	Latex Allergy	☐	☐
Heart Attack or Disease	☐	☐	Cancer	☐	☐	Sexually transmitted Dis.	☐	☐
Mitral Valve Prolapse	☐	☐	High/Low Blood Press	☐	☐	Emphysema	☐	☐
Arthritis	☐	☐	Stroke	☐	☐	Liver Disease	☐	☐
Heart Pacemaker	☐	☐	Chest Pain	☐	☐	Radiation	☐	☐
Organ Transplant	☐	☐	Hodgkin's Disease	☐	☐	Epilepsy or Seizures	☐	☐
Artificial Heart Valve	☐	☐	Thyroid Disease	☐	☐	Lung Disease	☐	☐
Heart Rhythm Disorder	☐	☐	Circulation Problems	☐	☐	Chemotherapy	☐	☐
Psychiatric treatment	☐	☐	Hyper/Hypo Glycemia	☐	☐	Glandular Disorders	☐	☐
Asthma	☐	☐	Tuberculosis	☐	☐	Autoimmune Disorder	☐	☐
Heart Surgery	☐	☐	Congenital Heart Dis	☐	☐	TMJ Problems	☐	☐
Rheumatic/Scarlet Fever	☐	☐	Hepatitis A,B,C	☐	☐	Glaucoma	☐	☐
Bleeding Disorder	☐	☐	Peptic Ulcers	☐	☐	Tonsillitis	☐	☐
Osteoporosis	☐	☐	Cortisone/Steroid Use	☐	☐	Difficulty Breathing	☐	☐
Sickle Cell Disease	☐	☐	Kidney Disease	☐	☐	Head and Neck Injury	☐	☐
Bronchitis	☐	☐	Drug/Alcohol Addiction	☐	☐	Malignant Hyperthermia.	☐	☐
Herpes	☐	☐	Diabetes	☐	☐	Jaundice	☐	☐