UPPER FORT DENTAL

PHONE: 204.783.2288
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WEB: WWW.UPPERFORTDENTAL.COM
ADDRESS: 108-305 BROADWAY, R3C 3J7, WINNIPEG MB

PERSONAL INFORMATION

Referred By: O Person O Radio O Website O Other O Male O Female

Last Name | First Name | Preferred Name

Mailing Address | City/Province | Postal Code | Date of Birth

Home Phone | Work Phone | Cell Phone | Other Phone

Email

Spouse/Parent(s) Name(s) | Patient/Parent(s)' Employer | Spouse's Employer

MEDICAL INFORMATION

Medical Doctor/Physician's Name: _____

Are you under a physician's care? Please circle. Yes or No

If yes, why? _____

Has your physician advised you to take antibiotics before dental procedures? Yes or No

Have you ever had a serious illness or surgery? Yes or No

If yes, explain _____

Please list all medications you are presently taking by name:

_____

_____

_____

Have you had an allergic reaction to any of the following? Please circle.

Penicillin Yes or No | Advil/Tylenol Yes or No | Codeine Yes or No

Latex Yes or No | Metals Yes or No

Other Medicine. What? _____

Have you been treated or do you have any of the following: Please circle.

Asthma	Yes or No	Heart Murmurs	Yes or No
Haemophilia	Yes or No	Von Willebrand Disease	Yes or No
Stroke	Yes or No	Kidney Disease	Yes or No
Pacemaker	Yes or No	Liver Disease	Yes or No
Hepatitis	Yes or No	Rheumatic Fever	Yes or No
Epilepsy	Yes or No	Artificial Valve Implant	Yes or No
Tuberculosis	Yes or No	Diabetes Type I or Type II (circle type)	Yes or No

Have you ever been treated for or told you have heart disease? Yes or No

Do you take any form of blood thinner? Yes or No

If yes, what? _____

Do you have high or low blood pressure? High or Low or Normal

If you have high or low blood pressure, is it controlled? Yes or No

Have you ever had radiation therapy, chemo treatment, or cancer? Yes or No

flip over

Have you bled excessively after being cut or injured? Yes or No

Have you ever taken Fosamax, Zometa, Aredia (Bisphosphonates) for osteoporosis? Yes or No

Do you have any condition, or problem not listed? Yes or No

If yes, what? _____

Do you smoke or use any other form of tobacco? Yes or No

If yes, how often? _____

If you are female, are you pregnant? Yes or No

If yes, due date? _____

DENTAL HISTORY

Previous dentist's name

How long has it been since your last dental visit?

Are you aware of any dental problems?

Are you happy with the appearance of your teeth?

Have you ever had any problems or complications with previous dental treatment? Yes or No

If yes please explain:

If an appointment must be rescheduled we require 48 hours notice. Messages can be left at all times, including evenings and weekends at 204-783-2288. We reserve the right to charge for missed appointments and/or failure to provide sufficient notice prior to a cancelled appointment. These fees must be paid prior to being seen at your next visit. You are responsible for these fees; your insurance company will not be billed.

We reserve the right to cancel an appointment if we are unable to contact the patient, parent or guardian 24 hours before the appointment time.

INSURANCE

Plan Number: _____

ID Number: _____

Subscriber: _____

Date of Birth: _____

I hereby assign my benefits payable from claims submitted electronically to Dr Carly Hamilton Dental Corporation and authorize payment directly to him. I authorize release to the dental benefits company the information contained in claims submitted electronically. I understand that the charges may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to Dr. Carly Hamilton for the cost of treatment provided.

_____

Signature of Subscriber / Date

RELEASE

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care, including the use of local anaesthetic as indicated.

I authorize the release of any information concerning my/my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information, including x-rays, concerning my/my child's health care, advice and treatment to another dentist, and/or health care professional I understand that I am financially responsible for payment in full to Dr. Carly Hamilton for services rendered.

I attest to the accuracy of the information in this chart.

Patient's/Parent's/Guardian's Name (Please Print) _____

Patient's/Parent's/Guardian's Signature _____

Date _____