Patient Information

DR. STEPHEN PHELAN

DATE: _____

PERSONAL INFORMATION

Name: _____
MR● MISS● MRS● MS● DR●

Prefers to be called: _____

Date of Birth: DAY _____ MONTH _____ YEAR _____

Home Address: _____

_____

_____ Postal Code _____

Home Phone: _____

Cell Phone: _____

Email: _____

Business Address: _____

_____

_____

Business Phone: _____

Occupation: _____

May we call you at work: YES● NO●

In Case of emergency we should notify

Name: _____
MR● MISS● MRS● MS● DR●

Relationship: _____

Daytime Phone: _____

Family Physician: _____

Phone and Address: _____

_____

Medical Specialist (1): _____

Area Of Specialty: _____

Phone and Address: _____

_____

Medical Specialist (2): _____

Area of Specialty: _____

Phone and Address: _____

_____

Are other family member's patients at our office? YES● NO● Name _____

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Primary Insurance Company _____

_____

Subscriber's Name: _____

Date of Birth: DAY _____ MONTH _____ YEAR _____

Employer: _____

Group Policy Number: _____

Division Number: _____

ID / Cert. Number:* _____

Secondary Insurance Company: _____

_____

Subscriber's Name: _____

Date of Birth: DAY _____ MONTH _____ YEAR _____

Employer: _____

Group Policy Number: _____

Division Number: _____

I/D Cert. Number: _____

I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically.
I also authorize the communication of information related to the coverage of services described to the named dentist.
This authorization shall continue in effect until the undersigned revokes the same.

Signature of Patient, Parent, or Guardian: _____ Date: _____

Medical History Questionnaire

Name _____ Medical Alert _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1 Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

NO● NOT SURE/MAYBE● YES● _____

2 When was your last medical checkup? _____

3 Has there been any change in your general health in the past year? If yes, please explain.

NO● NOT SURE/MAYBE● YES● _____

4 Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

NO● NOT SURE/MAYBE● YES● _____

5 Do you have any allergies? If you answered yes, please list using the categories below:

NO● NOT SURE/MAYBE● YES● _____

a) medications b) latex/rubber products c) other e.g. hayfever, foods

6 Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

NO● NOT SURE/MAYBE● YES● _____

7 Do you have or have you ever had asthma?

NO● NOT SURE/MAYBE● YES● _____

8 Do you have or have you ever had heart or blood pressure problems?

NO● NOT SURE/MAYBE● YES● _____

9 Do you have or have you ever had a heart murmur, mitral valve prolapse, or rheumatic fever?

NO● NOT SURE/MAYBE● YES● _____

10 Do you have a prosthetic or artificial joint?

NO● NOT SURE/MAYBE● YES● _____

11 Have you ever been advised by a doctor to take antibiotics before dental treatment?

NO● NOT SURE/MAYBE● YES● _____

12 Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?

NO● NOT SURE/MAYBE● YES● _____

13 Have you ever had hepatitis, jaundice, or liver disease?

NO● NOT SURE/MAYBE● YES● _____

14 Do you have a bleeding problem or bleeding disorder?

NO● NOT SURE/MAYBE● YES● _____

15 Have you ever been hospitalized for any illnesses? If yes, please explain.

NO● NOT SURE/MAYBE● YES● _____

16 Do you have or have you ever had any of the following? Please circle.

- chest pain, angina
- heart attack
- stroke
- shortness of breath
- prosthetic heart valve
- pacemaker
- tuberculosis
- lung disease (e.g. emphysema, bronchitis)
- liver disease(e.g. cirrhosis, hepatitis)
- cancer
- steroid therapy
- diabetes
- stomach ulcers
- malignant hyperthermia
- arthritis
- seizures (epilepsy)
- kidney disease
- thyroid therapy
- diet pill therapy
- drug/alcohol dependency
- mental/nervous disorder

17 Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.

NO● NOT SURE/MAYBE● YES● _____

18 Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, heart disease)?

NO● NOT SURE/MAYBE● YES● _____

19 Do you smoke or chew tobacco products? If yes, please indicate how much.

NO● NOT SURE/MAYBE● YES● _____

20 Women only: Are you pregnant or breast-feeding? If pregnant, when are you due?

NO● NOT SURE/MAYBE● YES● _____

21 When did you last see a dentist? Date: _____ Last X-rays: _____

22 Are your teeth sensitive to any of the following? Please circle

- cold
- hot
- sweets
- biting
- other _____

23 Do you have any emotional concerns regarding your dental visit? Please specify?

NO● NOT SURE/MAYBE● YES● _____

24 Have you ever had orthodontics, gum surgery, oral surgery or wisdom teeth extraction?

NO● NOT SURE/MAYBE● YES● _____

25 Does your jaw crack, pop, or hurt when opened? Has it ever locked open or closed?

NO● NOT SURE/MAYBE● YES● _____

26 Would you like to hear about options available to enhance your smile?

NO● NOT SURE/MAYBE● YES● _____

27 How much dental treatment would you say you have had?

- minimal amount
- moderate amount
- major amount

28 How much dental treatment would you guess you need now?

- minimal amount
- moderate amount
- major amount

29 Please rank the following in the order in which they would keep you from having ideal dental treatment? Please number

_____ fear of pain _____ cost of treatment _____ lack of time _____ lack of concern

CURRENT LEGISLATION REQUIRES ALL DENTAL OFFICES TO IMPLEMENT A PRIVACY CODE FOR THE COLLECTION, USE, AND DISCLOSURE OF YOUR PERSONAL INFORMATION AND RECORDS. THIS POLICY EXPLAINS HOW OUR OFFICE WILL USE YOUR PERSONAL INFORMATION AND OUTLINES THE STEPS WE ARE TAKING TO PROTECT IT.

1. Only necessary information is collected about you to deliver safe and efficient patient care.
2. Only pertinent information is used to communicate with other treating healthcare providers, including specialists, dental laboratories, and peripheral dentists
3. Your address and employer information is only used for efficient follow-up of treatment, care and billing, and to maintain contact.
4. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols.
5. Our privacy protocols comply with privacy legislation, standards of our regulatory body (the Royal College of Dental Surgeons of Ontario), and the law.

I UNDERSTAND THAT THE INFORMATION I HAVE PROVIDED IS CORRECT TO THE BEST OF MY KNOWLEDGE. I AGREE THAT DR. PHELAN AND HIS ASSOCIATES CAN COLLECT, USE AND DISCLOSE MY PERSONAL INFORMATION AS SET OUT IN THE ABOVE POLICY. I ALSO GIVE PERMISSION FOR THE DOCTOR TO USE ANY PHOTOGRAPHS TAKEN FOR LECTURING OR EDUCATIONAL PURPOSES.

_____ Date: _____ _____ Date: _____

Patient's / Parent / Guardian Signature Dentist Signature