6-4040 Creditview Road., Mississauga. ON L5C3Y8
T: 905 615 1078 • F: 905 615 0084

Dr PINTO & ASSOCIATES
FAMILY & COSMETIC DENTISTRY

Date: ______________________

All Information Is Strictly Confidential & Will Remain With This Office

Name: Mr.__ Mrs.__ Ms.__ Miss.__ ______________________________
Last First Middle

Address: ______________________________
Street Apt. #

____
City Province Postal Code

Home Phone #: ____________________ Business Phone #: ____________________

Place of Birth: ______________ Date of Birth: ______________ Marital Status: ______________
D/ M/ Y/

Occupation: ____________________ Employer: ____________________

Referred By: ____________________ Email: ____________________

Person Responsible for Account: ______________________________

Dental Insurance: Yes ____ No ____ Name of Insurance Co.: ____________________

S.I.N ____________ Policy #: ____________ Certificate #: ____________ Employee I.D. # ____________

Family Physician Name: ____________ Phone #: ____________ Last Visit: ____________

In Case of Emergency Notify: Name: ____________________ Phone #: ____________

Relationship: ______________________________

Office Policy

Payment for services rendered are expected at the end of each dental visit. (i.e. Deductibles, percentage not covered by insurance plan etc.)

Certain circumstances require special considerations. Please discuss these with our financial department.

Appointments: In order to treat you effectively, we will reserve an appointment time solely for you. We require your co-operation in keeping these appointments. If you can not keep your appointed time, we require 48 hours notice. Otherwise, a fee will be assessed.

***** Please confirm your appointment 24hours before your appointment time!!*****

Confidential Dental History

Are you currently under the care of a physician? .... Yes ____ No ____

Are you currently taking any pills, drugs or medication? .... Yes ____ No ____

Have you ever been hospitalized? Why? ____________ Yes ____ No ____

Do you have heart disease or a heart murmur? .... Yes ____ No ____

Have you ever had rheumatic fever? .... Yes ____ No ____

Have you ever had abnormal bleeding? .... Yes ____ No ____

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Do you have any allergies to any drugs or medicines? .... Yes ____ No ____

Ie. Penicillin, Aspirin etc./ please specify ____________ Yes ____ No ____

WOMEN: are you pregnant ? .... Yes ____ No ____

Do you have or have you ever had?

___ Heart Trouble /Attack	___ Nervous Disorder	___ Aids/HIV	___ Stroke
___ High Blood Pressure	___ Psychiatric Care	___ Cancer	___ Epilepsy
___ Low Blood Pressure	___ Diabetes	___ Venereal Disease	___ Arthritis
___ Chest Pain	___ Liver Disorder	___ Shortness of Breath	___ Ulcer
___ Blood Disorders	___ Hepatitis	___ Asthma	___ Swollen Ankles
___ Anemia	___ Kidney Disorder	___ Sinus Problems	___ X-Ray Therapy
___ Fainting Spells	___ Herpes	___ Abnormal Weight Changes	___ Malignant Hyperthermia

Have you ever had any illness not mentioned above? .... Yes ____ No ____

Confidential Dental History

How often do you see your dentist? 6 Months ________ Yearly ________ Other ____________

How long ago was your last dental visit? ____________

Do you have a specific dental problem at the moment? ____________

Have you ever been given dental hygiene instruction in: Brushing ____________ Flossing ____________

Have you ever had a reaction to dental anaesthetic (freezing)? .... Yes ____ No ____

Are any of your teeth sensitive to: Hot ______ Cold ______ Sweets ______ Other ____________

Do your gums bleed when: Brushing ____________ Flossing ____________

Are you aware of any loose teeth? .... Yes ____ No ____

Do you currently experience:

___ Ear Ache	___ Headache	___ Sore Gums
___ Bad Breath	___ Popping or Clicking in Jaw Point	___ Neck Pain
___ Nosebleeds	___ Unsatisfactory Dentures	___ Gagging
___ Spaced or Crooked Teeth	___ Discoloured Dark Teeth	___ Stained Teeth

On scale of 1-10 (1 being poor, 10 being excellent), how do you rate your smile? ____________

Why did you give this rating? ____________

Patient Certification and Approval

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

Signature (Patient, Parent/Guardian) ____________ Date: ____________

Consent for Treatment

This is certify that I, the undersigned consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, and I will assume responsibility for fees associated with these procedures.

Signature (Patient, Parent/Guardian) ____________ Date: ____________