GONZALES DENTISTRY PROFESSIONAL CORPORATION
129 GORMAN PARK ROAD
TORONTO, ONTARIO M3H 3L1
gonzales.dentistry@gmail.com

Tel. No.: 416-633-9855 **Fax No.: 647-344-4810**

Medical Alerts

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Date of Birth (MM/DD/YY): _____
Address: _____City: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____ E-mail: _____
Marital Status: _____ SIN #: _____ Driver's License #: _____
Whom were you referred by? (Please circle): Family _____ / Friend _____ / Online / Newspaper / Other: _____
In case of emergency please contact: _____ Contact Number: _____

WORK INFORMATION:

Employer: _____ Occupation: _____
Address: _____ City: _____ Postal Code: _____
Work Number: _____ Work Email: _____

If full-time student:
School: _____ Graduating year: _____

INSURANCE INFORMATION:

Primary Insured: _____ Insurance Company: _____
Group/Policy Number: _____ ID/Certificate Number: _____

If covered under spouse's plan as secondary coverage:
Name of Spouse: _____ Spouse Date of Birth. (DD/MM/YY): _____
Employer: _____ Insurance Company: _____
Group/Policy Number: _____ ID/Certificate Number: _____

MEDICAL HISTORY:

Name of Physician: _____ Address of Physician: _____
City: _____ Postal Code: _____ Office Phone Number: _____
Are you currently under medical treatment? YES / NO Reason (if yes): _____

Have you had an allergic or unusual reaction to any of the following? (Please check mark the boxes below)

	Yes	No
Aspirin		
Codeine		
Dental Anesthetic		
Penicillin		
Other:		

For Women Only	Yes	No
Are you Pregnant?		
Expected Date of Delivery (DD/MM/YYYY)		

Have you ever been treated for any of the following? (Please check mark the boxes below)

	Yes	No		Yes	No		Yes	No
Anemia			Hay Fever			Sinus Trouble		
Asthma			Heart Murmurs			Stroke		
Diabetes			Hepatitis			Tuberculosis		
Emphysema			Jaundice			Ulcers		
Epilepsy			Kidney Disease			Venereal Disease		
Glaucoma			Rheumatic Fever			Other		

Please answer all questions below:	Yes	No	Reasons
1. Have you ever been treated for AIDS-related complex?			
2. Are you taking any medications? If so, what are they?			
3. Do you have heart trouble? If so, what kind?			
4. Do you have high or low blood pressure? Is it controlled?			
5. Have you ever been required to take prophylactic antibiotics prior to dental treatment?			
6. Do you use tobacco products? If so, how often?			
7. Are you subject to fainting or dizziness? If so, how often?			
8. Have you ever had cancer or a tumor? If so, how was it treated?			
9. Have you ever had any major operations? If so, what kind?			
10. Have you ever been involved in a serious accident?			
11. Do you bruise or bleed easily?			
12. Have you recently had a communicable disease (i.e. Mumps, Measles, etc.)?			

DENTAL HISTORY:

Previous Dentist: _____ Address: _____
Phone Number: _____Fax Number: _____ Date of last visit (DD/MM/YY): _____

1) In past years have you been to a dentist on a regular basis? If so how often? _____
2) Are you presently in any dental pain? _____
3) Is any part of your mouth sensitive to temperature, pressure or sweets? _____
4) Have you ever had orthodontic treatment? _____
5) Do your gums bleed when brushing your teeth? _____
6) Do you have an unpleasant taste or odor in your mouth? _____
7) Do you get growth or swelling after tooth extractions? If so, for how long? _____
8) Have you ever gotten food stuck between your teeth? _____
9) Do you awaken with pain in your teeth or jaws? _____
10) Do you have frequent headaches or facial pain? _____
11) Are you aware of jaw clicking or popping while eating or yawning? _____
12) Do you ever get cold sores or fever blisters? _____
13) What is your major dental concern at this time? _____

PLEASE READ THE FOLLOWING CAREFULLY

Office Policy:

- Payment is required after EACH appointment for work done that day.
- We will gladly complete Dental Insurance Claim Forms with the following understanding;
    a) The patient is financially responsible for the entire cost of the treatment.
    b) Payment is to be made to "Gonzales Dentistry Professional Corporation" by the patient. The patient shall be reimbursed by the Insurance Company.

iTRANS:

- Benefits payable from claims submitted electronically will be assigned to Gonzales Dentistry and payment will be received by the Dentist directly.

I hereby understand and agree to the above.

_____
SIGNATURE OF PATIENT

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, CONSENT TO DENTAL AND ORAL SURGERY PROCEDURES WITH THE USE OF LOCAL ANAESTHETIC AND/OR RELATIVE ANALGESIA AS AGREED TO BE NECESSARY OR ADVISED BY THE DENTAL PROFESSIONAL, AND WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

PATIENT'S SIGNATURE: _____ DATE (MM/DD/YYYY): _____

GONZALES DENTISTRY PROFESSIONAL CORPORATION
129 GORMAN PARK ROAD
TORONTO, ONTARIO M3H 3L1
gonzales.dentistry@gmail.com
Tel. No.: 416-633-9855 **Fax No.: 647-344-4810**

CANCELLATION/ NO SHOW POLICY

- At least 24 hours notice is required if you must cancel/reschedule your appointment for any reason.
- Missed Appointments will incur a firm charge of $50.00
- All outstanding fees must be paid in full before further appointments will be booked.
- Should you miss an appointment, it is your responsibility to call and rebook.
- Frequent or numerous cancellations and/or no shows will result in permanent discharge from the practice.

Statement of Understanding

I hereby acknowledge and confirm that I have read the policy stated above. I agree to conduct my activities in accordance with Gonzales Dentistry Professional Corporation's policy and understand that breaching it in any way may result in disciplinary action.

Name of Patient: _____

Name of Parent/Guardian (if applicable): _____

Date Signed (month/day/year): _____

Signature: _____

*****THIS AGREEMENT WILL BE PLACED IN YOUR FILE*****