Gateway Dental | Dr. Larry Hoffman

789 McKeown Avenue, Unit #6 North Bay Ontario P1B 0C8
705-478-5885 reception@gatewaydentalnorthbay.ca GatewayDentalNorthBay.ca

PATIENT REGISTRATION

Name of Client: _____ Male Female

(Parent if CLIENT is under 16)_____ SIN# (optional) _____

Mailing address: _____ City: _____

Province: _____ Postal Code: _____ Birthday: _____

Home Phone #: (__) _____ Business Phone: (__) _____ Ext.____ Cell: (__) _____

Previous Dentist: _____ Email address: _____

Whom may we thank for this referral? _____

PERSON TO CONTACT IN CASE OF EMERGENCY Phone: (___) _____

Name: _____ Relationship to Client: _____

DENTAL INSURANCE Policy Holder Self Spouse Other

Policy Holder D.O.B_____ Place of Employment: _____

Ins. Company: _____ Policy#: _____ ID#: _____

We are committed to keeping your personal information private. By signing the consent form, you have agreed to give us your consent for the collection, use and/or disclosure for your personal information for the purposes that are listed in our Privacy Policy. If a new purpose arises for the use and/or disclosure of personal information, we will seek your approval in advance. A copy of our Privacy Policy is available in the reception area.

PAYMENT OPTIONS

To keep costs down and continue to provide quality dentistry, we can only accept payment in full, same day of service.
We offer the following methods of payment:

CASH / INTERACT VISA MASTERCARD

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% monthly interest charge (18% annually) will be added to any balance over 60 days. In the event of default, I (we) promise to pay any interest in the indebtedness, together with such collection costs and reasonable attorney fees as may be required, to effect collection of this note.

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

CONSENT

The undersigned hereby authorize the Doctor to take x-rays, study models, photographs or any other diagnosis of my (or the patients) dental needs. I further give my permission for the use of these photographs, x-rays and records to be used for the purpose of research, education or publication in professional journals. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I further authorize and consent that the Doctor choose and employ such assistance, as he deems fit. I also understand that the use of anaesthetic agents embodies a certain risk. Where possible, I will be asked for verbal consent or permission before any and all treatment is done and x-rays are taken.

Patient Signature _____ Date _____

or

PARENT OR RESPONSIBLE PARTY_____

RELATIONSHIP TO PATIENT _____

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Office Use Only
Initial BP: /

PLEASE COMPLETE ALL OF THE FOLLOWING:

DENTAL HISTORY

1. Are you having any discomfort at this time with your teeth?..... YES NO
2. Do you feel nervous about having dental treatment?..... YES NO
3. Have you ever had a bad experience in the dental office?..... YES NO
4. Do you smoke?..... YES NO
   How much per day? _____

HEALTH HISTORY

5. Physician's Name: _____
   Phone #: _____
6. Date of your last physical: _____
7. Specialist's Name: _____
8. Have you taken any medicine or drugs in the last two years?..... YES NO
9. Please list any medications you are PRESENTLY taking:
   _____
   _____
   _____
10. Do you have environmental allergies?..... YES NO
11. Do you have medical allergies?..... YES NO
12. Have you ever had a peculiar or adverse reaction to any of the following? (If Yes, please circle)

Penicillin	Amoxicillin	Sulfa	Aspirin
Dental Freezing	Nitrous Oxide	Latex	Codeine

Other (Please specify):
_____

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13. Circle any of the following health issues which you have had or have at present:

Acid Reflux (GERD)	Drug addiction	Lung disease
A.I.D.S	Emphysema	Lupus
Anemia	Epilepsy/Seizures	Malignant hyperthermia
Angina	Fainting/Dizziness	Migraine headaches
Anxiety	Fibromyalgia	Multiple sclerosis
Arthritis/Rheumatism	Glaucoma	Osteoporosis
Artificial heart valve	Head/Neck injuries	Pacemaker
Artificial joint (Hip or Knee)	Heart disease/attack	Pain in jaw joints–TMJ
Asthma	Heart murmur	Pneumonia
Blood disorder	Heart rhythm disorder	Pregnant–_____ mo
Bronchitis	Heart surgery	Psoriasis
Bruise easily	Hepatitis: A, B, C	Raynaud's syndrome
Cancer–Type–_____	High blood pressure	Shingles
Chemo/Radiation	Low blood pressure	Sinus problems
Cold sores	High cholesterol	Sleep Apnea
C.O.P.D.	Hormone replacement	Stomach/intestinal
Crohn's/Colitis	Inflammatory bowels	Stroke
Depression	Kidney disease	Ulcers
Diabetes–Type 1, Type 2	Liver disease/jaundice	

14. Do you have any condition, disease or problem not listed above?..... YES NO
    If Yes, specify: _____

15. When you walk upstairs/take a walk, do you have to stop due to either pain in chest, shortness of breath, or tiredness?..... YES NO

16. Do your ankles swell during the day?..... YES NO

17. Have you lost or gained more than 10 pounds in the past year?..... YES NO

18. Do you ever wake up from sleep short of breath?..... YES NO

19. Do you use more than 2 pillows to sleep?..... YES NO

20. Are you on a special diet?..... YES NO

Signature _____ Witness _____

Date _____ Date _____