Financial Information **(Please complete all information if different than above)**
Person responsible for account: Self__ Spouse__
Other_______________________________________
Name_____________________ Phone ( ) ______________
Address________________________________ City________________ Postal Code__________________

Policy Holder's Name_____________________ Date of Birth___________
Insurance Company_____________________ Policy Number________________
Certificate Number________________ Division Number________________ Annual Maximum_________
Employer_____________________ Phone Number ( ) _____________
Do you have: 3___ 6___ 9___ 12___ month recall coverage with your dental coverage?

IF YOU HAVE DUAL INSURANCE, PLEASE INFORM THE RECEPTIONIST

Dental History (please check **YES** or **No** to each question)
Date of your last dental visit_______________ Last dental cleaning______________ last xrays____________
Name of last dentist______________ Phone ( )__________________

		YES	NO
1)	Have you ever had any of the following		
	Periodontal treatment? (treatment of the gums)…………………………………………………..	Y	N
	Orthodontic treatment (straighten or align teeth)…………………………………………………	Y	N
	A bite plane or any other appliance………………………………………………………………..	Y	N
	Oral surgery(surgery in or about the mouth/jaw joint, or implant surgery………………………	Y	N
2)	Do your gums bleed when brushing or eating or do you suffer from pain or swelling of your gums	Y	N
3)	Have you noticed any loose teeth or have any of your teeth shifted………………………………	Y	N
4)	Have you been advised to take antibiotics before a dental appointment…………………………	Y	N
5)	How often do you brush your teeth_____ Do you feel you have bad breath……………………	Y	N
6)	Have you ever experienced any of the following jaw problems:		
	Popping/clicking in your jaw joints………………………………………………………………..	Y	N
	Pain in your jaw joints, around your ear, or side of your face……………………………………..	Y	N
	Difficulty in opening or closing……………………………………………………………………	Y	N
	Pain or difficulty while chewing…………………………………………………………………..	Y	N
7)	Do you clench or grind your teeth while asleep or awake………………………………………	Y	N
8)	Are there any growths or sore spots in your mouth………………………………………………..	Y	N
9)	Are you unhappy with the appearance of your teeth………………………………………………	Y	N
	If yes, what would you like to see changed?..		
10)	Have you ever had an upsetting experience in the dental office…………………………………..	Y	N
	If yes explain………………………………………………………………………………………		
11)	Have you ever had sedation (Nitrous Oxide "laughing gas/Intravenous(IV) for dental treatment	Y	N

Village Market Dental
Caring for your family for over 20 years

General Release and Privacy Policy

I, the undersigned certify that I have provided an accurate and complete personal and dental/medical history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my dental /medical history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of the information.

I , understand, consent to the collection of any and all personal information about me including my personal health information, and all personal information about any minor of whom I have joint or sole parent custody, and to use such information in any manner or for any purpose whatsoever, but only in the course of concerning, or relating to your dental practice. I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Professional Act, the Dentistry and Dental Hygiene Acts of Ontario, and to any insurer or other payment organization who may be responsible for payment of all or a part of any treatment or service this office provides. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols.

I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

______________________________ ______________________________

Signature of Patient, Parent or Guardian Please Print Name

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