7DENTAL

Welcome to 7Dental!

Patient Information

First Name: _____

Last Name: _____

Preferred Name: _____

Date of Birth (D/M/Y):_____

Home address: _____

(City)_____(Postal Code)_____

Employer:_____

Occupation:_____

Contact Information

Email Address:

_____

Mobile phone: _____

Work phone: _____ext:_____

Home phone: _____

Other phone: _____

Best number to contact:_____Time:_____

Whom should we call in case of an emergency?

Name: _____

Phone: _____

Whom may we thank for referring you?

On-Line ____ Location ____ Advertising ____

Friend (Name)_____

Medical History

Name of family physician?_____
Phone: _____
Date of last visit with physician:_____
Are you currently healthy? Yes_____ No_____
If NO, explain:_____
Do you smoke or chew tobacco?_____
Are you currently taking any prescription medications?_____ If yes, please list below:

Medication	Purpose

Have you had any serious medical problems in the past five (5) years? Yes___ No___
If yes, explain:_____

Have you ever been treated for any of the following conditions?

__Heart Attack/Stroke
__Heart Murmur
__Hepatitis/Jaundice
__HBP
__Epilepsy/Fainting
__Cancer/Chemo
__Stomach Ulcers/Gerd
__Diabetes
__Chronic Pain/Back
__Tuberculosis
__Psychiatric Problems
__Kidney Prob.
__Abnormal Bleeding
__Anemia
__Drug/Alcohol Abuse
__Aids

Have you been treated for any other illness not listed above?_____
If yes, explain:_____
Are you allergic to any medication?_____
Any other allergies?_____
_____

For Women

Are you pregnant?_____
If yes, how many months?_____
Is there anything else you feel you should tell us about your health that might affect how we care for you? Please explain: _____
_____

Dental History

Reason for your visit today?_____
_____
_____
_____

How would you describe the condition of your teeth and gums?
_____ GOOD _____FAIR _____POOR

Are you having discomfort or pain with your teeth or gums?_____
If yes, explain:_____

Date of last dental visit?
(m/y)_____

How often do you brush? _____

How often do you floss?_____

Do your gums bleed when you brush? _____

Have you experienced pain in your jaw joint?____

Have you been treated for Jaw Pain? ____

Patient Consent

I understand this information to be correct to the best of my knowledge. I understand that it will be held in strict confidence and used only to improve communications between the doctor and myself. I also give permission for the doctor or staff to use any photos or x-rays for educational purposes.

I have reviewed the information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that 7Dental can collect, use and discuss personal information about me as set out in the 7Dental Privacy Policy.

Direct Billing to Your Insurance

I request for my dentist to bill to my insurance directly and agree that in case of a nonpayment by my insurance, I will be responsible for any outstanding balance after each visit.

Patient/Guardian Name:_____

Patient/Guardian Signature:_____

Date:_____

Office Use Only

Admin Name:_____

Dentist Signature:_____

__Central __Blossom __Findlay __Tenth __Trim

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www.7dental.com **(613) 7-DENTAL**

Five Convenient Locations

Central Park (1234 Merivale Rd.)
Blossom Park (2950 Bank St.)
Trim Social (945 Old Montreal Rd.)
Findlay Creek (4772 Bank St.)
Tenth Line (2288 Tenth Line Rd.)
Kanata South (**Coming Soon!**)