YORK & BAY DENTAL OFFICE

This questionnaire was designed to provide important facts regarding your health history. The information you provide will assist in reaching a diagnosis and treating you safely. PLEASE PRINT.

PERSONAL INFORMATION

PATIENT INFORMATION **TODAY'S DATE (mm/dd/yy)**: _____

Name: _____

First Middle Initial Last

Age: _____ Date of Birth (mm/dd/yy): _____ Email: _____

Address: _____

City: _____ Province:_____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Ext._____

Medical Doctor Info: Name _____Phone/Address_____

Emergency Contact (NOT living with you) Name:_____ Phone: _____

How did you hear about us? _____

INSURANCE INFORMATION

DENTAL INSURANCE
Policy Holder Information: Name _____ Birthdate _____ (mm/dd/yyyy)

Occupation _____ Employer _____

Insurance Co. _____

POLICY / GROUP # ID / SIN # Div #

SECONDARY DENTAL INSURANCE (if applicable)
Policy Holder Information: Name _____ Birthdate _____ (mm/dd/yyyy)

Occupation _____ Employer _____

Insurance Co. _____

POLICY / GROUP # _____ ID / SIN # _____ Div # _____

AUTO INSURANCE (if applicable)

Policy Holder Name _____ Relationship to Policy Holder_____

Policy Holder Address _____

POLICY # _____ CLAIM # _____

Insurance Co. _____ City of Branch Office _____

Adjuster name _____

Adjuster's Phone No. (____) _____- _____ ext. _____ Adjuster's Fax No. (____) _____-_____

ARE YOU ALLERGIC TO: (CHECK IF 'YES')

☐ Penicillin ☐ Aspirin ☐ Anesthetic (Freezing) ☐ Codeine ☐ Other: _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN (PLEASE ATTACH SHEET FOR MORE SPACE)

MEDICATION	REASON

MEDICATION	REASON

HAVE YOU EVER HAD OR EXPERIENCED…. (CHECK IF 'YES' AND SPECIFY THE APPROXIMATE YEAR)

YES	CONDITION	NOTES
☐	Diabetes	
☐	Thyroid Problems	
☐	Glandular Disorders	
☐	Heart Disease	
☐	Blood Pressure Problems	
☐	Angina (chest pain)	
☐	Heart Surgery	
☐	Pace-Maker	
☐	Heart Valve Replacement	
☐	Circulation Problems	
☐	Bleeding Problems	
☐	Heart Murmur	
☐	Lung Disease	
☐	Asthma	
☐	Sinus Problems	
☐	Snoring / Sleep Apnea	
☐	CPAP Intolerant	
☐	Arthritis	
☐	Joint Replacement	
☐	Osteoporosis	
☐	Autoimmune Disorders	
☐	Pregnancy (current)	

YES	CONDITION	NOTES
☐	Liver Problems	
☐	Alcohol Abuse	
☐	Hepatitis	
☐	Kidney Problems	
☐	Drug Abuse	
☐	Cancer / Cancer Treatment	
☐	Smoking (past? / present?)	
☐	Ulcers	
☐	Psychiatric Care	
☐	Epilepsy / Convulsions	
☐	AIDS / HIV / STD	
☐	Child / Spousal Abuse	
☐	Family / Domestic Violence	
☐	Head / Face / Neck Injury	
☐	Concussions	
☐	Jaw Fractures	
☐	Car Accident	
☐	Eye Surgery	
☐	Alzheimer's	
☐	Anorexia / Bulimia	
☐	Chicken Pox	
☐		

CONSENT

1. Consultation with your medical doctor may be necessary to assure safe dental treatment.
2. Some dental insurance companies request information such as copies of X-rays or specific dental information to determine coverage.
3. The patient (guardian) is responsible for all costs and should be reimbursed by their insurance carriers according to the contract of their dental plan.

I hereby allow Dr. Yim to obtain/release information, as noted above, and as required:

Signature (or parent for children under 18 years): _____ Date: _____